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The National Association for Mental Health, Inc.

The Voluntary Promotional Agency of the

Mental Hygiene Movement

Founded by Clifford W. Beers

Objectives

The National Association for Mental Health is a voluntary organization working for the promotion of mental health; for the prevention of mental and nervous disorders; for the improved care and treatment of the mentally ill; and for the special training and supervision of the mentally deficient.

QUARTERLY MAGAZINE

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THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

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MENTAL HYGIENE aims to bring dependable information to every one whose interest or whose work brings him into contact with mental problems. Writers of authority present original communications and reviews of important books; noteworthy articles in periodicals out of convenient reach of the general public are republished; reports of surveys, special investigations, and new methods of prevention or treatment in the broad field of mental hygiene and psychopathology are presented and discussed in as nontechnical a way as possible. It is our aim to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials, and students of social problems will find the magazine of especial interest.

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ORIGINAL CONTRIBUTIONS

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1891–1950

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THE NATIONAL ASSOCIATION FOR MENTAL HEALTH

It will be noted that with this issue MENTAL HYGIENE passes on to new auspices, The National Association for Mental Health. This is but one evidence of the merger of the work of The National Committee for Mental Hygiene in a consolidation which includes also the work of the National Mental Health Foundation and the Psychiatric Foundation.

All three of these associations have been devoted to the goals that motivated Clifford W. Beers when he founded the mental-hygiene movement. The National Committee for Mental Hygiene was his formal creature, but beyond that he planted in the hearts of thinking people a concern for the mentally sick that could tolerate no injustice to them. This concern, though less organized, is planted very deeply. It has burst forth from time to time as an expression of impatience with the slow progress in this field, and will no doubt continue to do so as long as the support of the field is so inadequate.

The National Mental Health Foundation, one of the merging partners, was such an expression, stronger than previous ones, because like that of Clifford Beers, it sprang from first-hand experience in our mental hospitals, the experience of a few men as war-time attendants. It burst forth also in professional ranks as the Psychiatric Foundation, which was convinced that money could be raised for the broad purposes for which Clifford Beers worked, and this effort was spearheaded by the rating of mental hospitals. This combination

of qualities—long experience, impatience, and confidence—should bring into the new organization a merger, not only of three corporations, but of these three qualities which were Clifford Beers's own qualities.

I worked for many years at the side of Clifford Beers. I am sure that he would have been not a little disturbed by the efforts of the past two years to effect such a merger, for it meant the overshadowing of an organization about which his whole life was entwined. But I am equally confident that his practical sense and his belief in his goals would lead him to understand and to welcome the strengthening of his "baby," as he called the mental-hygiene movement, to meet the challenge of its second fifty years. He would be gratified to find that strong citizens of our country are devoting themselves to it as supporters, as board, and as staff, lending their resources to his movement at no small sacrifice to themselves.

The goals of the National Association for Mental Health are the goals of the mental-hygiene movement—the promotion of mental health, the prevention of mental and nervous disorders, the improved care and treatment of the mentally ill, and the special training and supervision of the mentally deficient.

The National Association for Mental Health has an outstanding board of directors, composed of leaders in business and in the professions. It includes persons who have devoted much of themselves and of their resources to this field. Its chairman, Arthur H. Bunker, did much to put the International Congress on Mental Health on its feet in 1948. One of its vice chairmen, Mrs. Percy D. Madeira, Jr., has been a long-time leader in the mental-health field in Philadelphia; and its other vice chairman, Dr. Harold W. Elley, has been a moving spirit in the effort to raise funds for the rating of mental hospitals. The treasurer, A. L. van Ameringen, has already given much time and effort to the securing of financial support for this field. Its president, Oren Root, has accepted his responsibilities as a personal challenge to which he is devoting full time. The medical director is Dr. George S. Stevenson, formerly Medical Director of The National Committee for Mental Hygiene.

GEORGE S. STEVENSON

DYNAMIC CONSIDERATIONS IN COMMUNITY FUNCTIONS*

GEORGE S. STEVENSON, M.D.
Medical Director, The National Committee for Mental Hygiene

THE ultimate task of the voluntary promotional agency, of which The National Committee for Mental Hygiene is one example, is to assist communities to provide better services for their people. Whether the scope of a voluntary agency is the world, the nation, the state, or merely the locality, whether it is concerned with health, social conditions, protection, education, or recreation, it must change the structure and function of the community; otherwise it is ineffective. Sometimes it must create new services; sometimes it renovates old ones. But whether its field is ostensibly in the psychological sphere or not, it works with and for people, as well as with their sick organs and their poverties, and its work is done better or worse as it respects or ignores the forces that bear upon human behavior.

This approach to social problems is fairly new. Until recently the forces that govern behavior were given little conscious attention. People helped one another by intuition, by trial and error, and on a common-sense basis. Common sense has its advantages, but also its limitations. It is forthright, but very subject to customs, and customs, when followed blindly, often work against as well as for success. In some places a life problem is considered the just desert of its victim; in other places, an accident of life that needs sympathetic and informed attention. Each decade confronts us with new social problems, problems that did not exist before. The community function, therefore, can never reach a final form, and customs seem to lag behind. We find that when customary procedures prove antiquated, we try to meet problems at first by this very informal common-sense approach, pending an analysis of the problem and a more rationally designed solution.

* Presented at a meeting of the New York Psychiatric Society, March 7, 1949.

But in the course of time, the ways of giving help to people have taken form, so that a community in the United States now seldom starts from scratch, even on a problem that is new to it. It looks about to see what other communities have done and tends to copy what looks like a good pattern. The forces that have made a pattern good, however, are generally not analyzed out and made available to the new community as a set of principles that can be a guide in designing a solution, custom-made for itself; so that this copying of a pattern developed to meet a different set of conditions is apt to be to a degree a misfit and to result in harmful as well as helpful approaches to a problem.

Even those who are professionally engaged in helping communities seldom start from a set of principles of community function. Instead, they copy patterns as a whole or in part. They do not take into account the fact that every community is unique and that the application of a single pattern to all communities tends to run counter to the distinctive qualities of each individual community. This tendency to use patterns instead of principles is probably due to the fact that those who help professionally in community organization are not scientifically trained and do not approach their professional work through the scientific processes.

When the community is seen as an organism with a history, with conditions and experiences of its own, it tends to take on a personality of its own that distinguishes it from a mere amorphous crowd. Some of our more rapidly developing communities—the mushroom communities of war time and the rapidly growing towns on the West Coast—have many of the features of a crowd, a fact that must be taken into account in planning their services.

It is desirable, therefore, that psychiatrists who have scientific preparation should try to identify dynamic forces and find general principles, in order that they may be used more broadly than they are at present. In that way the unique nature of each community can be considered in its planning, just as we consider each patient in need of individual understanding and service.

The Test of Community Function.—A basic dictum in community organization is that the resident of a community, the

person to whom service is given, must be the constant point of reference in the planning and in the judging of service. The community has evolved for the individual, and what happens to him is a measure of its success. This sounds obvious, but to-day success is much more often measured by standard patterns and traditions of professional prerogatives than by a study of what is happening to people. This dictum that the person is the base line has many corollaries and implications, the elaboration of which is the intent of this paper.

The Evolution of Community Function.—It may perhaps be of help, before discussing these details, to see for ourselves how community services come to be. This will help us to understand some of the mishaps of community services and to avoid mistakes when we try to correct these faults. In relatively new communities the steps that I shall describe occur in such rapid succession that they are often unnoticed or they may even be omitted. What I have to say is, therefore, something of a composite. It applies only to the more slowly developing parts of the country. Behind these steps is the fact that communities tend to develop functions that are needed, but that are too difficult for people to provide for themselves.

At first the help that people gave their neighbors who were in need or who had become nuisances was simple, informal, and palliative. The orphan child was taken in by friends of the family, who gave him a home. The person who was unable to read, write, or figure was drilled in those subjects without any attempt to take into account the reasons for his lack. As a second step, the public, the county perhaps, took these functions on as an official responsibility and paid the neighbor who gave this previously informal help. The mentally deficient dependent was put on the auction block and turned over to the lowest bidder, who judged his capacity to work as well as to eat. Then as a third step the county organized this function more formally by setting up its own almshouses. In doing this it not only formalized the function, but also in a way routinized and dehumanized it.

Dorothea Lynde Dix sponsored the fourth step in our own field and promoted the asylum for the mentally ill, in which counties in effect joined hands under state auspices to give better service than could jails or almshouses. To-day the

fifth step is in the making—that is, the transition from asylums to state hospitals in which scientific therapy, rather than poor custodial care, becomes the aim and in which good custody gives way as a base line to the best that science has to offer.

But there is still a sixth step, as yet undertaken nowhere except in small bits. It has still to be worked out experimentally. In this the concern of the state for mental health is not limited to or even focused on the mentally ill, but on the population generally.

The Community of Interest of Agencies.—As the public took over simple and direct services for various human needs, those public agents who were placed in charge of them included a few people who were not content with mere palliation. They looked for causes, in the hope of cure and prevention. They sought the causes of delinquency, dependency, mental illness, poor health, school failures, and ineffectiveness on the job. But it happens that the factors that produce these major social problems are not specific for these problems. Back of all of these problems lie important common factors, and in most cases a multiplicity of factors related to several scientific disciplines. Therefore, any one who seeks the factors behind any of these problems finds himself rubbing elbows with the other people who took off from a different start.

This is where we are to-day in our more advanced interagency progress. As cause and effect and the relationships between problems are coming to be understood, human problems take on a more complex and dynamic significance. One field of science and service definitely relates to and affects another. This rubbing of elbows between the fields is, however, not, as a rule, at least at first, a friendly contact. Those who have worked back into the causative area of the problem with which they are concerned are apt to think of their extended scope as the proprietary right of their own professional group, for it is in fact an extension of their professional area. They have not yet learned of its similar relationship to other problems.

And so there come to be competition and quarrels with those who have entered this preventive territory from different directions. Each claims the leadership as to housing, cul-

tural conflict, social tensions, economic factors, and so on. The result is tension, if not open hostility, between the community agencies. A common conflict of this sort is found between relief and public-health-nursing agencies, each claiming the family. Some of these conflicts are augmented by other factors; the social worker, for example, resists regimentation that is a part of and, to a degree, a very necessary safeguard in the case of the nurse.

It may be, however, that some special contributions are coming out of these conflicts. Those who get tangled up in them are apt to be upset about them through failure to see that they may mean something desirable. These conflicts are the first evidence that the agencies of the community have come close enough together to have conflicts. As long as they worked in a simple, palliative way there was no trouble, but also there was no awareness in their work of the fact that they were sometimes all serving the same client. They dispensed their wares without trying to put them together, integrated in a way comparable to the integration of the person they were trying to help. They left it to him, already anxiety-ridden and bewildered, to correlate what they themselves, though professionals, had been unable to put together. The stage of inter-agency tension means that the gap is closing and that the isolation and separation of agencies are coming to an end. Through the contact, even though it involves conflict, mutual understanding and then collaboration become possible. And only when such collaboration is achieved will the community meet the test of our basic dictum that the services of the community be measured by their values to the person served. In fact, a chart of a well-developed community is also a chart of a functioning person.

The Community as One Agency.—This need for integrated service to a community has many interesting sides to it. It means that instead of several agencies, which in the aggregate make up the community, it is sounder to think of the community as one comprehensive agency for its people. Then public health, education, social work, public safety, industry, the church, recreation, the court, and other agencies become parts of the whole, parts that depend upon one another. No longer, then, can any one of these claim full authority even within

its own sphere, for if its work is good, it helps to make all the others good and vice versa. Others have a stake in the quality of work done in its field. The attitude of you-tend-to-your-business-and-I'll-tend-to-mine is untenable, for "your business" is "my business."

The practical point of this for us is that mental-hygiene planning for a community cannot be restricted to the agencies that are specifically labeled as mental hygiene. The mental health of the community is in the hands of the schools, the courts, and many other agencies.

In the light of this single-agency idea, some of our practices may well be reviewed. The staff conference for case discussion, as developed in the child-guidance clinics some thirty years ago, is especially significant as an integrating force. The clinic itself began with a team of three professions—the psychiatrist, the psychologist, and the psychiatric social worker. But when they had discovered how to work together, they soon found it useful to bring in the teacher, the social worker, the probation officer, the public-health nurse, the family doctor, and others concerned with the child as indicated. They came together in whatever combinations the needs of the child called for, and it often meant that in the powwow, the leadership for the work on the child passed from the clinic to some other agency, because an approach from another direction seemed to offer more promise in the treatment of the problem involved.

In some communities an effort has been made to achieve unified action within the community by the creation of an omnibus agency wherein "all" the needed services are provided by additions to the court, or the family agency, of a psychiatrist, a nutritionist, or some other specialist. This seemed on the surface to be a good start. I believe, however, that it is a vain hope and potentially obstructive, for it assumes that all the needs of the person can be met in this way. We know that they cannot. If the agency were able to expand itself to meet all these needs, it would be identical with the community as a whole, would eliminate all other agencies, and would then have to subdivide these community departments in a way that would in effect be the separate agencies that we have to-day. The belief that an agency can meet all its needs in this way

relieves it of the necessity of working out its relations with other agencies. The proposal has also been made that each community have a central in-take agency where cases will be sorted and referred. This proposal ignores the dynamics of the search for help, of which I shall speak shortly.

Fostering Inter-agency Ties.—The concept of a community as really one large agency forces us to face up to the problem of how the division of labor in a community can best be effected, and shortly I shall suggest that the criterion be technical specialization rather than merely strategic location at the portal of problems. The Travelers Aid Society may seem like a portal agency, but short-term case-work and interurban communication are technical specialties.

This idea of a community as a single agency also has a bearing on the efficiency of community effort and its way of growing. Since social change is continuous, the community services should progress accordingly. In practice, however, progress occurs not through continuous change, but by stops and starts—steplike. It even includes backward steps. This must be remembered in order that the failure of the community to move ahead promptly may not cause discouragement. I used to feel that I had wasted much time and effort in working with a community in planning for a clinic, only to find, two or three years later, that it had not moved ahead. But invariably the enthusiasm for a clinic would rise again and show a higher level of appreciation than the first interest. I believe that this type of development is sounder than a precipitous beginning.

It is obvious that if one community agency grows far ahead of the others, it will absorb money and public interest and slow up the progress of the others. It will, in fact, soon find that its own work is hampered because it lacks the support of equally advanced work elsewhere in the community. It is interesting in this respect that some tuberculosis associations have made a place in their budgets and in their buildings for the support of mental-hygiene activities and, wisely, have avoided simply absorbing these activities as an omnibus agency. It behooves a health department, therefore, to back the budget of a school system that is lagging even if this is done at some sacrifice to the health department's own expan-

sion. Our present bureaucratic practices are completely out of line with this enlightened self-interest and really stifle their own advancement.

A rural community, with its simple organization, seems to be able more easily to retain the perspective of the whole. This in part accounts for the fact that one often finds excellent examples of community organization and perspective in rural areas even though technical refinements may be less developed. The best school work I have ever seen has been rural. I believe we have missed a great deal by keeping our attention on the city for our leadership.

The factors that enhance the relationship between agencies are so much a part of their everyday work that it is obvious that only the most general direction can be exercised from without. If it is expected that one agency, like a council of social agencies, can dictate this unity, it obviously will never come about. However, such a council can facilitate its development. So much of the tone of the various agencies is set by their national promotional organizations, such as the American Psychiatric Association, that these national agencies become a large factor in fostering or combating bureaucracy. It is important for these agencies and for the community to realize that every time a field introduces a change conceived only in terms of that one field, confusion is apt to result. This can be prevented only by a study of the needs of the whole community and a program that takes into account the relationships between the various fields.

The National Committee for Mental Hygiene for many years surveyed communities with the aim of improving mental-hygiene services. Those who want surveys may merely want a count of cases. This is seldom of value in our field, where gross variations in incidence do not exist. Some want the survey to report and to emphasize facts that they already know. When an outsider says the unpleasant things, he departs with the figurative brickbats following him, leaving the community informed, but still harmonious enough to make progress. A third type of survey studies the relations or potential relations between a mental-hygiene agency and the other agencies to see how they can collaborate effectively and avoid wasted effort. Such a survey is highly valuable.

Every agency, then, is an agency of community organization and unless it has a full perspective and is aware of the forces involved, it may do the community a disservice. The overlap between agencies seems very irritating to some of those who are concerned with community organization. Of course a great amount of overlap is wasteful, but a certain amount of it is an insurance of inter-agency coördination and, indeed, corresponds to the fact that the human functions and needs represented by these agencies are not naturally sharply separable. Neither are the facts of science naturally divisible as they appear in books and curricula.

This continuity is also violated by most institutions and agencies which grow, not by evolving to a higher level through rearranging the services they are performing, but by adding the new without changing the old. This is but one expression of institutionalization, whereby agencies become stiff and unchangeable. Again and again a community wants to start a clinic in part to deal with cases that could be handled by the improvement of non-clinical services such as schools or courts. Such a clinic has the odds against it from the start and really pauperizes the growth of agencies upon which it must depend as an earlier line of defense.

The third type of survey mentioned tends to reveal such a tendency and to permit another approach before it is too late. Institutionalization is in part dependent on the vested interests of the existing staff. A full response to the needed changes would often require replacement of staff or perhaps a regrooming of staff for new functions.

Defining the Scope of the Agency.—In determining how services should be set up in a community—how the labor should be divided—several facts need to be considered. First of all, agencies have to deal with people as such, quite apart from the specific problems they present. An orthopedic clinic, for example, must deal not only with bones, but with the social and emotional components of the patient. The concept of the clinic's scope does not include this as a real responsibility and so it is usually handled rather blindly. Secondly, people often disregard the specific field of an agency and go for help to the agencies that helped them before or that have a reputation for having helped some one else. People in need do not

analyze their problems sufficiently to make application to exactly the right agency. If an attempt is made to sort applicants for help into the several specialties at the beginning, at the point of their seeking help, the value of their confidence in a particular agency is lost. Third, there are well-established technical fields—medicine, public health, law, social work, recreation, and so on—and it would seem as if the division of labor in a community might well be determined along these technical lines.

Community Departmentalization.—In contrast to the omnibus agency, there is much to recommend the division of labor in a community along these technical lines, the degree of specialization varying according to what will afford good administration. Thus, the agencies for a larger population would each show a greater degree of specialization than those in a rural area. According to this principle, the client should receive his services primarily from the agency or agencies that are technically competent in relation to his basic and most urgent need. The technical function concentrated in one agency can be adjusted to the needs of the client by a rather easy functional decentralization, so that a technician from one agency may actually work elsewhere if that is where the clients are found and where service can be rendered them more effectively. Thus the department of health might provide medical-inspection personnel for the schools for the ordinary pupil whose needs are primarily educational, or, on the other hand, schools might provide teachers for the educational unit in a hospital.

While such a division of labor may seem rather hard and fast, its specialization makes it even more necessary that interagency collaboration be provided for. In this way the aims of the omnibus agency are met by *ad hoc* combinations at the point where the best service can be rendered. It may thus be better to keep the client at the family agency, and have the psychiatrist consult about or actually treat him there, than to burden him by sending him to several other addresses. Some child-guidance clinics have been working in this way for twenty-five years.

In spite of its state auspices, the mental hospital is really a community department of psychiatry. In the beginning,

the state hospital represented a coöperation between communities for the purpose of attaining a better quality of psychiatric service. Since it is a community department, the mental hospital might have been expected to grow, as have other departments of community service, and to provide local leadership in developing remedial and preventive work. It has been slow in accepting this responsibility, but the more progressive mental hospitals seem inclined to take this side of their work seriously. A comprehensive program of the state hospital will provide for coverage; that is, it will deal with the psychiatric needs of its community in something approaching its entirety; it will provide a satisfactory quality of service; it will give active support to other community services that inevitably influence mental health; and it will work closely with these services.

As people sought personal and neighborhood assistance for their delinquent children, guidance in their inability to make ends meet financially, positive health programs as a buttress against epidemics, and education for other things than erudition, they encountered obstacles that ran beyond the range of service provided by the teacher, the social worker, and the other functionaries working in these fields. People became increasingly frustrated with problems resulting from personality and behavior disorders and thus created a demand for psychiatric help in order to improve their level of living. If the psychiatric agency were situated in the local community, geographically and administratively close to the need, it would probably have met these newer demands more rapidly. The remoteness of the mental hospital, which is the community's chief resource for psychiatric service, has made this adaptation difficult.

Progress in the mental hospital has tended to come from influences only within itself and to refine more and more the intra-institutional services to its traditional patients. It belongs to and feels for no one community because it serves many communities. Its distance from its communities has even affected its work on its traditional patients. For example, it is half a century since we came to appreciate the value of knowing the home setting of mental-hospital patients, of discharging the patient into a suitable environment, and of con-

tinued after-care treatment (follow-up) in the community after discharge. These community responsibilities have been recognized as important to the patient in the same way as the services performed within the hospital. But these services are not to-day generally provided as a part of psychiatric service to a community, though they are an earlier step in the progressive growth of the hospital than service to non-hospital patients. In spite of the extension in 1943 of the Federal Vocational Rehabilitation Act to the mentally handicapped, few states as yet use it because it complicates administration to extend the hospital to the community. It is important to face these realities, for unless we understand the dynamics of the way social functions become fixed into institutions, and how new human needs are thereby lost sight of, we are apt to be caught unawares, surprised, indignant, and frustrated, without a lead as to the way out. When we see these realities, we are in a position to deal with them and to find an answer to the needs of people.

The psychiatric division of community function has greater handicaps in extending its scope than do some other divisions, because the established psychiatric function to-day is geographically and functionally remote from the locus of need and from modifying influences. In some states it is hundreds of miles from the person who needs its help. Its job of dealing on a large scale with life-and-death problems and of making decisions for others forces it to be conservative. Its size, the investment it represents, and the law impede change. The simplicity and security of life of its personnel induce conservatism. All of these things must be dealt with if the hospital is to serve as the official or leading psychiatric department of its communities. It is obvious that the assumption of new functions to meet community needs requires changes that affect nearly every phase of the mental hospital's work and that, therefore, resistance is inevitable. When function extends beyond the gate of the hospital, it is less under control and administration is bound to be more difficult.

Yet human needs tend to find a solution and this out-patient community psychiatric need is, therefore, looking to other leadership than the existing authority. In our larger and more privileged communities, there is local provision. This

is reasonable and might well be the objective of the constituted department of psychiatric service. By developing the local resources of the more privileged communities, the state is freed to concentrate its efforts on communities that are less well endowed. This equalizing function of the state is an established principle. It is only necessary that a clear relationship be worked out between these locally provided psychiatric services and the state authority, so that patients will not suffer by falling into the gaps between them.

In some places the tendency exists to set up a small intensive-treatment center when the public becomes discouraged about reforming the state hospital. This, of course, will deprive the state hospital of its treatment function and degrade it still further. There is also no justification for the tendency to set up a separate state authority for out-patient service, since the paroled patient is bound to suffer if the hospital is deprived of this responsibility. Yet this is the only practical expedient in some places to-day.

Generic Help.—But, as I have pointed out, people tend to seek help where they have received help before. The teacher, the social worker, even the librarian, are called upon for help with problems quite outside of their specific fields. Sometimes a person seeking help can be put on the right track with little confusion or loss. The teacher can steer him to a court or a family agency. But in other cases the sensitive teacher will see that this involves too much risk. He senses that it took a lot of effort from friends or family, or courage on the part of the client, to get as far as this in seeking help, and he sees that the chances of discouragement are great if all help is deferred by referring the case elsewhere, or perhaps he recognizes that it has been the teacher himself personally, or what he has done before for this individual, that has emboldened the individual to seek help again. He may know that this confidence cannot, at least peremptorily, be transferred to some other who has technically more to offer.

This is a dilemma that confronts all fields. It implies that there must be a common basic competence on the part of all health, social-work, education, and other personnel to deal with human problems. Each must possess a competence that is somewhat above that of the population generally. Each

one of the various technical fields must know the simpler problems that people encounter, what to do for them and what not to do. Such knowledge and skill do not come by chance or common sense. They are not now included in professional curricula; in fact, their content is not even agreed upon. We need some kind of inter-professional conference to consider this common generic function, to define its scientific content, and to make recommendations as to its inclusion in professional training. As far as we have been able to define this generic function to date, it would involve: (1) the capacity to interview; (2) an understanding of anxiety, its causes, and what it may do to people or for people; (3) an understanding of the forces involved in family relations; and (4) a knowledge of community services and how to use them.

Factors in Community Organization.—I indicated earlier that every agency that is concerned with one area of community function is a force in community planning and must see the whole if it is not to be confusing. There are certain general principles that all fields must keep before them:

1. The strengthening of a community lies in its own leadership. The task of the agency is to find it, study it, back it, strengthen it, and promote it, not to front it. This is sometimes difficult to understand. It is so easy to step in and do a job that seems to need doing, even though doing it from the outside fosters dependence and weakens those who would normally have this responsibility.

2. To strengthen community leadership, it would be helpful if the outside national organization could give assistance to all communities in securing personnel for their vacancies, but if resources are limited, it would be better to help them to fill key posts only, with recognition of the fact that once these have been manned with competent persons, the subordinate positions will be filled more wisely.

3. From time to time national agencies are requested to give some kind of certificate of approval to clinics and hospitals. It is interesting that good clinics and hospitals seldom request this. It is usually the ones that have doubts about their own quality who seek that kind of assurance.

4. Again and again the stimulus for the establishment of a clinic in a community is not merely the absence of service for

frankly psychiatric cases, but also the desire of other than psychiatric agencies to make progress without disturbing their own routines. For example, a juvenile court, in order to do its best work, needs especially equipped judges who know something besides law, and probation officers who are trained as social workers. Some juvenile courts lack these resources and would like to have every child studied by a clinic and thus save themselves the discomfort of making internal improvements. A clinic established in such a community is almost doomed to failure because, on the one hand, it will have a larger load than it can carry and, on the other hand, will have a little coöperation with other agencies on its cases.

5. It is obvious that since many mental-hygiene problems first appear in other than medical agencies, these agencies should be recognized as a part of the mental-hygiene structure of the community. From this standpoint the public-health nurse becomes one of the most important mental-hygiene functionaries. She comes on the scene with the newborn child before adverse conditions have come into full play. She operates within the home and is in a position to influence its atmosphere. The teacher, though she comes along after many of the influences that bear upon the child have come into full play has, nevertheless, a duration of influence on the child that warrants her being considered the second most important mental-hygiene functionary.

6. Identification of the influences that bear upon the mental health of the individual is best made through a study of cases of social breakdown. This opportunity is, for the most part, wasted at present. Communities have so much anxiety about delinquency and other social problems that their main efforts are focused on patching up the individual case and they do not see the lessons that each case holds for the whole community.

7. There is considerable danger, when local services are thought of merely as extensions of a state hospital—especially in the smaller communities, where the staff is on a traveling basis—that the implications, for the community, of the case of social breakdown will be entirely lost. It is for that reason that the authority for such service should be focused on the community as much as possible, and wherever such services

are set up, local boards are needed in order to capture the more subtle implications of the case for the whole community.

8. One of the mistakes usually made by clinics centered in the hospital rather than in the community is that the service is apt to be rendered on the basis of county or some other political subdivision rather than according to the way people live. A clinic will be set up at a certain point perhaps because it is the county seat, even though the people served normally shop and get other services in a town across the county line. In fact, the way people tend normally to live is taken into account especially badly in large urban districting. In New York City, for example, the schools, the health department, the police, and so on, district the city so differently that it is impossible for agencies to get together in providing joint services for any one neighborhood.

9. The development of local responsibility means the development, not merely of a few leaders, but of a feeling of responsibility in the whole citizenry. Without that the service is apt to be in a state of constant instability.

I have tried by example and by principle to describe some of the forces that may be taken into account in meeting the mental-hygiene needs of communities. They are in fact principles that apply to all community organization. This formulation is rudimentary. I hope that you for whom the dynamics of behavior is a daily preoccupation will keep these principles in mind in order that they may be constantly further refined.

THE FUTURE PSYCHIATRIC PROGRAM OF THE VETERANS ADMINISTRATION *

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THE concept of mental hygiene has to do essentially with the prevention of mental illness, and it might thus appear a contradiction in aims for mental hygienists to be concerned with large public mental hospitals. Their efforts might seem most logically applied extramurally, since, in a sense, every patient admitted to a neuropsychiatric ward is beyond the sphere of preventive measures—is, indeed, a testimony of the inadequacy of their application.

There are two obvious reasons why the mental hygienist may legitimately investigate psychiatric practice within hospitals. In the first place, it is to be assumed that hospital patients are victims of unhygienic personal and social living. In other words, scrutiny of their case histories should yield valuable clues as to what is faulty living in the broad sense. Material gathered from these patients should point to undesirable stresses, poor adaptation, insufficient support, and ineffectual prophylaxis in their past experience.

A second concern of the mental hygienist is the maintenance of mental health in those patients who recover from incapacitating breakdowns. The application of preventive methods to the reconstructed lives of former patients is a severe proving ground where these methods should be carefully studied. Since the laying of the groundwork for and the initial guidance into the patients' improved living take place in the hospital, intra- and extramural assistance are inseparable, and the mental hygienist must perforce concern him-

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self with hospital practice in general and treatment in particular.

Principles such as those just enumerated have influenced the post-war administrative reorganization and professional functioning of Veterans Administration neuropsychiatric services. In the administration, a vigorous campaign is being waged against the isolated, custodial psychiatric hospital of the past. Such an institution is an aimless eddy outside the main current of modern psychiatric practice. No psychiatric institution to-day can justify its existence as a custodial community for socially ostracized souls. Improved treatment methods, improved understanding of dynamic psychiatry, the improved discharge rates of the better hospitals, and improved public education, all serve to emphasize that psychiatric hospitalization must no longer be considered a lost interlude or a final scene in the life drama of a sick person.

The modern psychiatric hospital is a corrective educational institution in which individuals are received in a state of more or less dysfunction from a stressful culture, to be reshaped and retrained preparatory to their rejoining the culture. I think of those picturesque relics, the covered bridges of New England, in which a traveler sought brief refuge from the storm, to wring out and rearrange his clothing, catch his breath, recover his strength, revise the schedule for reaching his destination, perhaps plan an alternate route, and, if necessary, wait out a particularly violent upheaval of the elements. The psychiatric hospital, too, should be primarily a place of temporary respite. Both ends, for admission and for discharge, should be wide open, and the whole structure should stand astride the main highway, not demanding of the distraught traveler that he turn off onto a side road, difficult to retrace to the turnpike.

Some of the measures instituted by the Veterans Administration in its psychiatric hospitals to defeat social and medical isolationism are well known to you and need no detailed explanation. Paramount among these measures is the rapid development of mental-hygiene clinics with the express purpose of keeping patients out of the hospitals. An estimated 25 per cent of the veterans who attend the fifty-seven mental-hygiene clinics are diverted from hospitalization and receive

psychiatric help while remaining within their social settings. Rehabilitated former hospital patients also are aided in the clinics and their readjustment to the rigors of daily living facilitated. The clinics, therefore, are practicing mental hygiene in the best sense by attacking incipient illness and by discouraging relapse.

A second principle of revolutionary proportions is the attempt to destroy the physical and functional isolation of the old Veterans Administration hospitals. Plans for new construction include the placing of hospitals in population centers rather than in isolated rural areas. Affiliation has been completed with forty-four medical schools for consultation service and for aid in maintaining residency training programs. Working relationships have been developed with numerous schools, colleges, and universities for the education of clinical psychologists, social workers, nurses, aides, and other ancillary personnel.

The neuropsychiatric hospital is being converted into a general hospital by the establishment within its bounds of good medical and surgical departments. Neuropsychiatric units are being set up in hospitals formerly devoted to medical and surgical illnesses only. In these ways, Veterans Administration psychiatry is being returned to the general field of medicine, from which it should never have strayed, and to the community in which its patients live.

Another anti-isolationist move of value has been the wide extension of social service. Since the social worker's chief function, his reason for being, is to assist patients with their social problems, it follows necessarily that his inclusion on the staff will influence orientation in the direction of the patient's environment. The introduction in many psychiatric hospitals of a vocational-rehabilitation section will in like manner have a salubrious effect.

Direct relations with the community are expanded through the special-service divisions which, among their various other activities, recruit, train, and orient interested laymen for work with patients. The rise of volunteer services in psychiatric hospitals has had a remarkably beneficial effect on the patients, on the personnel, and on the volunteers as well. The community enters the hospital in the persons of the

volunteer workers, and we hope that the spirit and effectiveness of the hospital will inspire each volunteer to return to the community as a Veterans Administration ambassador. The administration has encouraged participation by its personnel outward into community life. A gratifying extension of interrelationships is indicated by requests to the administration from an increasing number of lay organizations and civic groups for lecturers and after-dinner speakers. The Veterans Administration responds to this voluntary solicitation for information and instruction of a psychological-psychiatric nature as generously as its speaker resources allow.

Space is not available here to list all the specific measures that are being put into effect. I merely wish to emphasize that the isolated, custodial psychiatric hospital is a medical anachronism and that the Veterans Administration is making every effort to remove it from the contemporary scene.

I wish to discuss now an aspect of the Veterans Administration neuropsychiatric problem that bears the stamp of uniqueness. Much of what I have just said might be applied to any psychiatric hospital system. However, the Veterans Administration hospital differs from all others in that its patients are drawn exclusively from a large, restricted segment of the total population. The predominant interest is in male patients of two age groups. The average age of the 3,700,000 living veterans of World War I is 55 years as compared with 30.5 years for the 14,000,000 World War II veterans. It is from these two groups that our patients come, and from no other. The number of female veterans in the latter group is comparatively negligible. Consequently, we are in the remarkable position of being able to predict our average case-load years ahead, and beyond that to predict the kinds of psychiatric illness that we shall see. Here is an opportunity for pre-planning so tremendous that it weighs as a heavy responsibility.

It has been estimated, for example, that the total neuropsychiatric-patient load will mount continually until 1957, when it will rise more sharply to a crest of about 125,000 in 1965. We know something of the diagnostic categories, year by year, with which we shall be dealing. This knowledge comes from the following data:

1. Schizophrenia is manifested in 70 per cent of the cases by the age of thirty and is rare after forty; therefore we anticipate a slackening of first admissions with schizophrenia and a gradual accumulation of chronic cases.

2. Manic-depressive disease reaches its peak between the ages of forty and forty-nine, although onset in many cases is at fifty or sixty. Seventy per cent of patients with manic-depressive disease are women; therefore, we expect a small, but even expansion in admission for this illness.

3. The involutional period for men is age fifty to sixty-five; therefore we are prepared for a growing incidence of involutional melancholia for the next ten years from the World War I group.

4. Alcoholism, to be chronic, must have existed for a number of years. The maximum incidence of psychoses with alcoholism falls in the forty-to-fifty-four age range. Delirium tremens is rare before thirty, and Korsakoff's syndrome before fifty. A uniform upward curve of admissions and readmissions for alcoholism is in prospect.

5. Paresis, syphilis of the brain, develops usually between thirty and fifty. The incidence of paresis that will develop in World War II veterans is unknown because newer treatment methods for primary and secondary syphilis were used. The trend is expected to be higher by small degrees.

6. Pre-senile and senile psychoses will increase moderately and steadily as World War I veterans advance in age. The whole specialty of geriatrics will eventually be our chief concern.

7. Similar forecasts are possible for many numerically minor illnesses such as Huntington's chorea, paranoid states, and so on.

Some of the implications of these figures are that Veterans Administration strategists are in a fortunate—and awesome—position to plan treatment, discharge, chronic case load, architecture, diet, social work, training programs, research, and many other facets of psychiatric practice and mental-hygiene investigation. The very ability to predict one's future reduces the validity of excuses for shortsightedness.

With its most urgent medical responsibility past the post-war emergency phase, it is now incumbent upon the admin-

istration to perfect its treatment facilities and educational program and particularly to set in motion its projected research activity. Since it is dependent upon public funds, the development of investigative facilities is uncertain, but what is certain is the profusion of material presented for the inquiring mind of the professional worker.

Projects should be planned and instigated now to study the potential patients with involutional melancholia, including social background, environmental stress, endocrine balance, brain waves, sensorium, response to treatment, and subsequent adjustment.

The increasing number of chronic schizophrenia and other syndromes challenges the Veterans Administration to plan and build revolutionary hospitals, farms, colonies, and foster-home-placement services for a large-scale inquiry into chronic mental illness.

The strong tendency of veterans to return to the Veterans Administration hospital network when their illness recurs offers an unparalleled opportunity for study of the contributing social factors of relapse and for investigation of the treatment responses of relapsed patients.

Geriatric problems are mounting in the general medical field, and no specialty is more concerned than psychiatry with ways to solve them. The rehabilitation of arteriosclerotic and early senile patients offers yet much virgin territory to the intrepid Veterans Administration explorer.

I have detailed only four from the scores of possible Veterans Administration research projects that promise extension of psychiatric knowledge and acquisition of more effective prophylactic tools. Whether or not these unprecedented opportunities can be exploited is not yet clear.

The Department of Medicine and Surgery of the Veterans Administration is a governmental medical agency. As such, it is associated with the United States Public Health Service, the army medical corps, and the navy bureau of medicine and surgery. These three sister organizations operate hospitals and treat patients as does the Veterans Administration, but their outstanding accomplishments, their really inspiring traditions, have been in the field of preventive medicine. The anti-syphilis campaign, the anti-tuberculosis activities, the

maternal-child-health program in rural areas, the eradication of yellow fever, the control of malaria, the investigation of leprosy, are among their invaluable gifts to healthier living. It is this type of contribution that should be the principal long-range function of governmental medical departments.

The private practitioner of medicine serves his individual patients. His moral and legal responsibility is to sick individuals. The public medical agency serves the aggregate body of citizens and its responsibility is to the public welfare. It is impossible to divorce such a governmental department from the treatment of patients, but it is equally impossible to maintain it as a living force in medicine unless it can also contribute to general medical knowledge and practice.

The Veterans Administration hospital system was designed for semi-emergency treatment in the immediate post-war period of World War I. Of the three basic needs of good medical service, it emphasized treatment only, ignoring research and education. Therefore, it sank within a few years to near oblivion, becoming, particularly in psychiatry, a series of custodial institutions. The directors of the present Veterans Administration have indicated their determination to prevent a recurrence of this situation and, instead, to maintain the department of medicine and surgery as a vital contributor to American medicine and living. One meaningful way to realize this objective is through clinical research oriented toward preventive medicine in the public interest.

THE PRESENT STATUS OF RESEARCH IN DEMENTIA PRAECOX*

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ANY attempt to survey systematically the present status of basic research in dementia praecox must start out with an adequate appreciation of the fundamental features that have characterized developments in this field for the last fifteen or twenty years. At no time during the history of psychiatry has such rapid and comprehensive progress been made in the scientific investigation of all the aspects of this disease. We have come to know more about its causes and manner of development, and we have gained new insight into the relationships between its so-called physical and mental phenomena; its psychological structure and its symptomatology have been more clearly outlined; an impressive number of new methods of treatment has been introduced; and more exact methods of evaluation, prognosis, and rehabilitation have been made available.

The reasons for this progress are quite obvious and are largely to be found in the fact that the psychiatric research worker has come to realize the value of venturing outside of the boundaries of his own sphere of activity and has made good use of contributions from allied sciences. The work stimulated and subsidized by the Committee on Research in Dementia Praecox, which can undoubtedly be regarded as one of the most important contributions in the field, represents an outstanding example of this trend. The rapid strides that have been made in the study of intermediary metabolism, central-nervous-system physiology and chemistry, the function of the endocrine system, the development of human beings in relationship to their social milieu, the mechanisms of infant behavior and the importance of early childhood experiences, the dynamics of anthropological and sociological phenomena,

* Condensed from a report to the Committee on Research in Dementia Praecox of the Supreme Council, 33rd Degree Scottish Rite, Northern Masonic Jurisdiction, U.S.A., based on a survey of research activities in the United States and Canada.

all have opened up new avenues of approach for the study of the factors responsible for the development of dementia praecox and its effects upon the individual and upon the group.

Running parallel to these developments, and frequently stimulated by them, has been the introduction of an unprecedented number of new methods of therapy, such as electric and insulin shock, psychosurgery, and endocrine treatment, on the one hand, and new insights and possibilities in the use of various psychotherapeutic methods on the other. All of these not only have given a new and practically oriented impetus for research, but, what is more important, they have given us possibilities for scientific investigation that have never before been available to the research worker.

All this should quite naturally be very encouraging and, therefore, it is particularly surprising to find that in the face of all the progress that has been made, the work that confronts us seems, not only not to have been lightened, but actually to have increased. The incidence of the disease seems to have reached greater proportions; its influence on society has increased in scope; and the mechanisms of its development seem more complex than ever before. But this is a paradox that is unfortunately characteristic of all scientific work and is probably best expressed in the words of the Preacher: "*Qui addit scientiam addit atque laborem.*" The progress that is made by research opens up new fields, and the new problems that are brought to our attention surpass by far the few that our research has solved.

Our investigations of dementia praecox have actually taken us a long way from the very limited, even if comforting, concept that was held by our predecessors. Morel's original idea of a small number of hereditary degenerates, the Kraepelinian concept which limited itself to the comparatively narrow circumference of a deteriorating psychosis of adolescence, and even the broader concept of Bleuler of a process disease, are not sufficiently comprehensive to cover the present scope of the illness. Modern psychopathology has shown the untenability of a clear-cut demarcation of dementia praecox both from the neuroses and from the psychopathies and has made it necessary to push its boundaries further and further away from the central core of the original definition.

Time and again, in my visits to various institutions during the course of my survey, it has been brought to my attention that the disease is far from being limited to hospitals for the mentally sick, but is actually more prevalent outside of them.

One group, for instance, has come to realize that a large proportion of the patients previously diagnosed as character neuroses are really suffering from early manifestations of dementia praecox. Another group points out that we must get away from emphasis on the treatment of patients who already are incapacitated and in state hospitals and reach out for the more prevalent and at the same time therapeutically much more promising problems of the so-called ambulatory cases of dementia praecox. Then again the work that has been carried on for years now in the field of child behavior has brought to light the fact that in order to understand dementia praecox, we must start out with study of the normal child—its problems in adjustment and the social and psychological factors that influence it.

At the same time stimulation from fields outside of psychiatry and psychology has given us new and vastly greater areas of investigation. Studies in brain metabolism, the functions of the endocrine glands, electrophysiology, cerebral blood flow, enzyme chemistry, and frontal-lobe physiology have all opened up new problems, although they have also introduced new methods and techniques. Finally, deeper insight into the development, not only of the individual, but of society, contributed by the studies of social psychologists, sociologists, and anthropologists, while adding to our knowledge, has also increased the labors that lie ahead.

I am emphasizing these points, because I think that a proper appreciation of them is essential, if we are to understand the need of wide excursions into fields that on the surface seem to have very little to do with the patient who is suffering from dementia praecox. At the same time, it serves the purpose of making us aware of the complexity of the problem when we try to determine what is important and promising in basic research.

Scope of the Survey.—The survey that I undertook for the Committee on Research in Dementia Praecox officially started on June 10, 1949, and was concluded on September 12. Actually

a great deal of preliminary work was done before that in the way of interviews and correspondence with a number of active investigators, to decide upon the scope of the study, the institutions that I should visit, the subjects that I should investigate, and the limitations I should set for myself in view of the rather short period of time available. Also, since the conclusion of the general survey, I have made occasional short trips to some of the institutions that I had not visited before. At all of these I have sought counsel on the most advisable methods of attack on the problem, and have interviewed individuals in regard to their work and their concepts of the relative importance of investigations in special fields.

The greater part of the work, however, was carried on through actual visits to the institutions in which, on the basis of my own knowledge of the field and that gained from my advisers, I felt that the most intensive and the most promising research work is being done. The institutions visited are spread throughout the United States and Canada, from Toronto to Galveston, and from Seattle to Boston. The survey covers 75 separate institutions in which I have observed the work of and have had extensive interviews with over 200 scientists actually carrying on investigations in this field. Most of these institutions are connected with medical schools, but a number of them are independent. The investigators represent various fields, including psychiatry, psychology, physiology, chemistry, internal medicine, surgery, child behavior, pediatrics, sociology, anthropology, physics, and mathematics.

Although my main function was that of an investigator, and, therefore, involved listening rather than talking, asking questions rather than answering them, observing rather than contributing, I realized very early in my survey that in order actually to appreciate what is going on, it was necessary to develop a closer contact with these institutions and the people working in them, and to participate as actively as possible in the functions of the particular places visited. I sat in on formal conferences and plain bull sessions; I interviewed, not only independent investigators, but also some of their assistants; I watched procedures both scientific and clinical. More frequently than I actually intended to, but at the request of

the people whom I visited, I contributed to general discussions or made specific suggestions, particularly on the basis of what I have seen in other places. In the main, however, it was primarily a matter of actually seeing these investigators at work, examining the results that have already been obtained, and eliciting plans for the future. I watched animals being operated on, apparatus at work, chemical analyses in process, psychological tests being given. I observed therapeutic sessions through one-way screens, analyzed accumulated data, and discussed their implications.

I also felt that in order to get an adequate appreciation of the conditions under which some of these people are working, it was frequently necessary to talk with deans of medical schools and superintendents of hospitals at one end of the line and technicians and trainees at the other end.

The Material.—This report will not include a complete account of all the projects that were surveyed, but will restrict itself to a general indication of the more important trends, with perhaps an emphasis on certain outstanding examples of promising work in each one of the fields. It is obvious that a plan of this type presents difficulties, the most important of which is that of categorization of these trends. Research in this field, obviously, does not lend itself easily to a division into categories. We could, for instance, start out with the traditional dichotomy of basic research as contrasted with the practical application of its findings to everyday therapeutic or preventive work. I long ago discovered, however, that it is difficult and sometimes impossible to differentiate between what is basic research and what is its application to practice, because the one merges so easily into the other. Thus psychoanalysis, which started out as a method of therapy of certain personality problems, has led to certain discoveries in the study of child development which have opened new possibilities for basic research in that field. Psychosurgery, which started out as an almost empirical method of treatment, has led to the study of the physiology of the frontal lobe, and in a good many places it is quite easy to see that the lobotomies performed for the purpose of therapy also provide valuable opportunities for basic research.

The reverse is also true. Thus, for instance, the results

of basic research in endocrine functions is now being utilized in the treatment with ACTH and Cortisone. Similarly, anthropological, sociological, and particularly child-developmental research, which started out as basic investigations, have led to the establishment of the practical application of the facts discovered to a systematic attempt at prevention, such as, for instance, is being utilized in mental hygiene in general and in the child-guidance clinics in particular.

This is also true, not only of problems in general, but of certain particular investigators. One man starts out originally to do basic investigative work and ends up in the midst of a therapeutic program, while another, who starts out working primarily with patients in therapeutic procedures, may be led to important basic-research work. Finally, it is also true that quite a few of the investigators I have interviewed and the institutions I have visited combine not only the two phases of any particular subject, but a number of subjects at the same time.

These difficulties involved in classification of research must be kept in mind particularly, since in actuality we find that a definite trend toward grouping does exist and can be utilized in presenting a systematic survey of the various projects. It depends primarily upon the degree of emphasis that is placed upon either one of two major points of departure: (1) the immediate practical needs presented by the patient and his problem, and (2) the fundamental mechanisms of the nature of the disease and its causes. On this basis our material can be arranged in a series of categories, some of which fall primarily into the first group, others into the second, while still others represent combinations of both.

Most typical representatives of the first group are the projects that are primarily concerned with the investigation of methods of treatment. Closely allied to these are the projects that deal with methods of evaluation, diagnosis, and prognosis. The former naturally lead over into the search for the *mechanisms* that underlie the successful therapeutic methods. The latter lead to investigations of the *structure* of the disease, including the biological, psychological, and social aspects of it.

It is at this point that we become particularly aware of

crossing boundaries. In the first place, we cannot investigate either the mechanisms of treatment or the structure of personality disturbance without getting into a number of areas other than psychiatry—namely, general medicine, psychosomatics, physiology, anatomy, sociology, psychology, and the like. Secondly, it is impossible to carry on any of this work without the aid of the knowledge and the techniques that are available in the realm of the basic sciences. This leads, therefore, into the group of basic-research projects, most typical of which, as far as research in dementia praecox goes, are: (1) child development and constitution as representative of the origin of the disease, and (2) biochemistry as the ultimate of its biological structure.

It was interesting and, to me, most encouraging to find that both qualitatively and quantitatively the projects that belong in the last two categories (child development and biochemistry) were definitely in the lead. They include the highest number of active projects in progress; the work is most systematized and reliable; the investigators are enthusiastic and ingenious. I must add, of course, that this statement is obviously based on the work in the institutions that I visited and may not be true of others. Also, it does not mean that excellent projects are lacking in other fields. It does, however, indicate a general trend.

The studies in child development, in so far as I consider them relevant to the problem of dementia praecox, fall into three general groups: (1) study of the development of the normal child; (2) study of factors that lead to deviations in child behavior; and (3) study of psychotic children who show disturbances that are more or less like those of dementia praecox.

Again, the most impressive and perhaps the most basic work is being done in the first of these groups. Generally speaking, the attack of the problem in this aspect of child development could be stated as follows: studies of the development of the average child, considering as many as possible of the factors that enter into this development and influence it, and the relationship of the subsequent behavior both of the child and of the adult to these influencing factors. This means, of course, a gradually increasing sphere of relation-

ships and the necessity of starting the study as early as is at all possible for the purpose of determining the importance of these factors.

Actually, in a good many of these projects, the investigators start out with a study of the mother before the child is born, in order to determine her own psychological and physical state, and the interrelations between her and the group, particularly the family. The attitude that she has toward her husband, toward her family, toward this particular child, the acceptance or rejection of the coming child, and the anticipations, hopes, and fears that she presents, are all closely observed. This leads to a study of the occurrences during pregnancy and delivery, and the study both of the infant and of the mother directly after delivery.

There follows a study both of the child and of his milieu and the behavior of both as a result of the interaction. Observation and the gathering of data are most important. Treatment is secondary, since in most cases it is not called for. The value of this work is obviously great. Since a few of these children will develop problems, we will in this way have reliable data in the case both of patients and of controls, and at the same time be able to study, on the basis of first-hand information, the whole process of the development of the disease against a general background of child growth. The most impressive examples of this type of work are those of the Forest Hill project in Toronto, the child research study in Denver, the Rochester Child Health Centre, The Children's Centre in Roxbury, Massachusetts, and the studies in Topeka.

The second group in this category is concerned with study of the development of deviations in child behavior that do not actually reach the proportion of psychoses. Outstanding examples are the Toronto studies of "recessives"; the work in Louisville, Philadelphia, Minnesota, and San Francisco with delinquents; the work in St. Louis, Detroit, and Denver and in a number of other centers. This group of studies is obviously closely related to, and frequently confluent with, the studies in the first group. The emphasis, however, is on the attempt to determine the nature of these deviations and their dependence upon the social, psychological, and physical setting in which the child grew up. A great deal of attention is given

to the potential relationship of these deviations to dementia praecox and the possibility of their being forerunners of the disease.

Finally, we come to a number of investigations that belong to the third group—that is, the study of psychotic children. Here we find an attempt to determine the causative factors combined with the search for and the utilization of specific methods of treatment. Outstanding examples of this group are the Children's Centre in Roxbury, the Orthogenic School in Chicago, Harriet Lane Hospital in Baltimore, and Bellevue.

Equally impressive, both qualitatively and quantitatively, are the projects in the general field of biochemistry. The field is very broad and reaches over into a great many allied fields, such as physiology, clinical endocrinology, psychosomatics, and so on. In as much as it can be delimited at all, however, one finds that the main impetus for these projects comes from the areas of metabolism, enzyme function, and steroid chemistry. The direct relationship of some of these projects to the problem of dementia praecox may not appear to be as obvious as it is in the case of others, but they all combine to provide a solid foundation for the study of human behavior. Here we have some of the best examples of investigations that at their inception seemed far removed from the problems of dementia praecox and then emerged right in the center of the problem. This is true of the chemistry of the 17-ketosteroids, the nucleo-proteins, the enzymes, and others.

The number of excellent projects in this field is obviously too large and their ramifications too complex to permit of an adequate analysis or even a comprehensive enumeration in this report. Outstanding at the present time are the projects at the Worcester Foundation, at Western Ontario University in London, at Western Reserve in Cleveland, at St. Elizabeths Hospital, at the University of Minnesota, at the Illinois Neuropsychiatric Institute, at the Mayo Clinic, and at the University of California. Added to this phase of chemistry is the work that developed on the basis of the various therapeutic methods in which drugs were used, such as the barbiturates, CO_2, cytochrome C, and so on. I have found very promising work in this phase in such places as the University of Iowa, the

Illinois Neuropsychiatric Institute, the Pennsylvania Institute, and the University of Texas, just to mention a few. Finally it is important to emphasize that it is in the field of biochemical research that we find the most impressive demonstration of how valuable the contributions of other sciences can be to psychiatric research.

Closely related to the basic studies in biochemistry and serving as an intermediary field leading toward the more practically oriented therapy projects, we find a large group of investigations dealing with the biological structure and function of the person. Here we find projects in the fields of general physiology as well as neurophysiology and more specifically electrophysiology and the functions of specific parts of the nervous system. Ketty and Schmidt's work on cerebral blood flow and the effects of drugs is beginning to present possibilities of practical application to the study of patients. The Greystone projects are utilizing lobotomy experience in further clarifying the pathological processes in the frontal lobes. Bishop and O'Leary are now ready to apply their results of years of research in cortical activity to the study of neurological and psychiatric disorders. Neuroanatomical and neurophysiological studies of the hypothalamic and thalamic nuclei, in progress both at Iowa and at Boston University, indicate leads in the direction of some forms of dementia-praecox behavior.

Several projects are concentrating on the function of the sympathetic and parasympathetic systems and their relationship to dementia praecox and to other forms of mental illness. Such are the projects that are in progress at Payne Whitney, at the Boston Psychopathic, in Toronto, in London, Ontario, and in Seattle. A good many of these projects are actual outgrowths of practical investigations of newly introduced methods of treatment. In some cases the original purpose of improving therapeutic techniques has been maintained, and the results certainly warrant continuation. In the case of the somatically oriented therapeutic methods, this is particularly true of the projects dealing with shock therapy and psychosurgery.

The same holds true of projects that have been started in various institutions in the field of psychotherapy. The much

discussed Rosen method is being followed in a number of places, the ones that impressed me most being those in Topeka and at the Pennsylvania Institute. Investigations have also been started on the value of group therapy, and those at St. Elizabeths and at Boston State Hospital are yielding promising results.

Organized research in individual psychotherapy in dementia praecox is perhaps most effectively represented in the concerted effort made by the staff of the Chestnut Lodge, in Rockville, Maryland. Various aspects of the problem, such as the process of communication in this treatment, the transference-countertransference relationship, criteria for measuring the effect of the treatment, and so on are systematically followed by special groups of workers, and the data are periodically discussed by the whole staff. The work of this group also demonstrates an extension of the essentially practically oriented investigation of the effectiveness of therapeutic procedures into the area of the psychological and social structure of the process. The disturbances of the functions of thought and language, the effects of dementia praecox upon the social setting, and the importance of the interpersonal relationships in the therapeutic process are being systematically investigated by them.

A number of other workers are concentrating their efforts on the psychological and psychopathological structure of this disease. Experimental work on disturbances in thought and language is particularly well represented in Wisconsin and in Worcester. Disturbances in perception in reaction to psychological stress and in concept formation are being systematically investigated in the Illinois Neuropsychiatric Institute, in Iowa, in Topeka, and at Duke University. Here, too, we find a number of studies of the general structure of the personality, particularly on the basis of projective tests. Most of these investigators are dynamically oriented and their analysis of the structure of the disease frequently leads to a search for the factors involved in its development.

Two main trends are particularly strongly evident. The contributions that have been made by psychoanalysis have led to a number of investigations concerned with experiences in infancy and childhood, and their effects upon the development

of tendencies toward withdrawal from reality. Outstanding in this group of projects are those in progress at Western Reserve, at the Illinois Neuropsychiatric Institute, at the New York Psychiatric Institute, in Topeka, and at the Roxbury Children's Centre, to mention just a few. Another group is concentrating its research in the general fields of sociology and anthropology, as, for instance, at the University of California, Harvard, and Duke University. All of these studies finally lead to and merge with the studies of child development that were described earlier.

It is surprising, and somewhat discouraging, to find that the other area of research that would most naturally come to mind at this point—namely, the one dealing with constitution—is not receiving as much attention as would be expected. Franz Kallmann seems to be the only investigator who is convinced of the need and feasibility of investigating this phase of the problem and is carrying on systematic and effective work in this field.

Finally, I would like to focus attention on an area of research that has only recently begun to attract the interest of investigators in dementia praecox—namely, the general subject of the so-called psychosomatic relationships. The importance of psychosomatic research in general medicine, and particularly in the shadowland that lies between the somatic diseases and the psychoneuroses, is now fairly generally accepted and needs no further elaboration at this point. Within the last few years, however, a number of workers have been able to demonstrate the applicability of this concept to research in dementia praecox. In the first place a number of careful observers have found the existence of close relationships between the dynamics of development of such illnesses as asthma, ulcerative colitis, diabetes, and so on and those of dementia praecox. They have also found that under certain conditions, transitions of the one into the other can be observed. Another link between the two has been suggested by the most recent experiences with the use of ACTH and Cortisone in both arthritis and dementia praecox. Active research in this area is in progress in such institutions as the Chicago Psychoanalytic Institute and the University of Chicago, the Worcester Foundation and the Worcester State

Hospital, the Mayo Foundation, the Payne Whitney Clinic, and the Boston Psychopathic, to mention just a few. The potential value of such work in furthering our understanding of the nature of the disease and the possibility of controlling it is obviously very great.

But there is another even more fundamental aspect to this phase of the work. When I started the presentation of the material in this report, I took my point of departure from the patient and his illness. From here on it looked as if we were destined to end up in the usual dichotomy of the organic versus the sociopsychological aspects of the disease. On the one side, we were led from the illness through the physical methods of treatment to anatomy and physiology and finally to basic research in biochemistry. On the other side, we progressed through the various psychotherapeutic techniques to the social and psychological structure and finally to child development and constitution.

Actually, however, as I moved from one institution to another and was able to gain a better perspective, I became aware of the fact that through a broader application of the fundamentals of psychosomatic relationships, one could conceive of an ultimate convergence upon a single focus of what appeared to be divergent lines. The importance of stress, physical as well as emotional, in affecting the endocrine functions and homeostasis in general, and thus reflecting itself in ultimate biochemical changes, is one step in that direction. The possibility that the capacity of the endocrine organs, particularly the adrenal cortex, of the adult to respond to stress, may be affected by too heavy a load imposed upon the infant, is another step. To these we should add the work in child development, particularly in regard to early infancy and the importance of emotional stress situations in affecting future adjustment.

Finally, we have the more recent concepts of constitution as represented, not by a "*fait accompli*" at conception, but by an aggregate of hereditary characteristics that may be modified in individuals by environment, and of hormonal function as possibly an important part of the constitutional matrix. As we follow the emergence of these trends, we can also discern indications of a growing tendency to combine them

in research directed toward a common goal. To me this was the most encouraging aspect of present-day research in this field, holding out the promise of understanding human adjustment as expressive of the function of a total organism.

SUMMARY

The report of this survey should not be considered as a comprehensive account of all the work that is being done in dementia praecox in the United States and Canada. A number of institutions that are doing good work in this field have not been visited simply because of lack of time. I felt that if I were to attempt to visit all these institutions, I could not do justice to any one. Furthermore, in the institutions that I have visited, I was able to concentrate only on certain aspects of the work, since the time that was allotted to each one did not permit of going into any greater detail. This means that, from the point of view of comprehensiveness, this survey leaves much to be desired.

At the same time, however, it may be regarded as a good cross section of the main trends of present-day research in this field. I feel justified in saying this because, in the first place, the projects that I have seen represent virtually all of the areas that are currently being reported in the literature on the subject. Secondly, from discussions with each individual investigator, I was able to get an account, not only of his own work in the particular subject, but also of the work of others investigating the same area.

I should add, furthermore, that the adequacy of insight one gains in a survey of this type is much more valuable than the mere accumulation of data. The latter one can get from reports in the literature or from papers presented at meetings. None of these, however, will provide as satisfactory an evaluation of the quality or the potentialities of research work as can be obtained when one actually observes a man working in his own laboratory or with his patients. One gets an opportunity to learn his attitude toward the work, his scientific integrity, the degree of his enthusiasm, and, what is even more important, what he is like as a person.

I have also gathered some general observations that may be of importance. In the first place, wherever I went I found

a great deal of interest in the research activities of other institutions. It seems to me that if it were possible for all the investigators whom I have met during this survey to undertake trips similar to mine at least once in their lifetime, they would be able to do much better work, avoid duplication, and gain inspiration from others. Since such opportunities are not available, I found these investigators sincerely appreciative of the first-hand information I could bring to them. This lack of opportunity for scientific contact could be found in some places even between members of separate departments in the same institution. Time and again I found psychiatrists baffled by problems in the solution of which the internist or the physiologist could have helped, particularly when they were actually engaged in work on these problems, but the psychiatrists were not even aware of the fact that such work was being done in their own institution. In some instances, my visit was the first occasion for contact between these workers and frequently resulted in the development of plans for coöperative ventures in research.

It must be pointed out again that this report is offered primarily as an indication of general trends and not as a complete presentation of the results of the survey. The material is available, however, for a more comprehensive and objective statement, which it is hoped can be published in the near future.

In conclusion, may I be permitted to express to the Committee on Research in Dementia Praecox my profound sense of gratitude for this unique experience that I have been privileged to have. It has given me a new outlook on the potentialities of research in mental disease, it has enriched my knowledge of methods of approach, and it has opened up to me a new perspective of the ultimate goals. Finally, it has given me the opportunity of gaining better insight into the minds and souls of the people engaged in research and, through a process of identification, has strengthened my own determination and enthusiasm for this work.

WHAT DO WE KNOW ABOUT DEMENTIA PRAECOX?*

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THE enormous amount of damage to humanity caused by the disorder called dementia praecox or schizophrenia is evident everywhere and the general magnitude of the problem can scarcely be overstated or exaggerated.

The incidence of this disorder in the population of the world is very high. It is probable that as many cases of dementia praecox are outside hospitals as in them, since there are obviously large numbers who are making an adjustment of sorts, often a marginal one, in the community, or who are receiving therapy in private and never get to the hospital.

Dementia praecox is a disorder that belongs clinically in the field of mental medicine—the realm of the psychiatrist—and I wish to emphasize here that although we recognize the need to enlist the aid of as many scientific disciplines as possible in our search for working plans and causes, this need is not determined particularly by the failure of psychiatrists to solve a problem within their own specialty. The psychiatrist understands the problem in all of its manifestations and ramifications better than anybody else. His failure to solve the problem is no ordinary failure and the problem is no ordinary problem.

Similar situations in other fields of medicine have arisen. For example, cancer is a clinical problem faced in internal medicine and surgery, which at present has no solution so far as etiology is concerned. Medical specialists, therefore, are seeking help in several branches of chemistry and physics. We are thus well justified in seeking help in any field that has anything tangible to offer. Moreover, any type of science moves ahead most decisively when new techniques become available for the examination of life phenomena; and when

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new criteria are found, additional light is thrown upon the subject under investigations.

Dementia praecox being one of the great medical, social, and often personal problems of life, it has confronted us with a recognized difficulty. We have been able to define that difficulty, and are now in the midst of the third scientific step —namely, controlled observations and experimentation aimed at the solution of the difficulty. In any field of science it is necessary to insist that theories, ideas, and speculations, in order to be countenanced, must be accompanied and tested by experimental work or observations made in accordance with scientifically controlled procedures.

The noted scientist, Pasteur, stated that science is "built up of successive solutions given to questions of ever-increasing subtlety, approaching nearer toward the very essence of phenomena." This remark is especially applicable to research in the field of schizophrenia. Almost every general technique that has proved effective in determining the causes and control of physical diseases as such has been tried in the field of schizophrenia without notable success. Some of these attempts have been in bacteriology, in the search for an infectious agent; some in serology; some in the field of diet and nutrition; others in neuropathology and physiology; and still others in pharmacology, where scores of old and new drugs, so successful in the treatment of other disorders, have been tried only to be abandoned eventually.

Of course, some of these approaches are still promising and have opened up inviting leads, and a certain number of therapeutic interruptions and shifts in the clinical picture of individual cases have been effected.

One cannot but be impressed with the number and wide variety of etiological factors in schizophrenia reported during the last twenty years. Some of the factors held accountable are highly hypothetical and theoretical; some are the result of assumptions constructed on insufficient evidence; while a few are based on careful experimental work.

The current theories on etiology can be arranged rather easily into two categories: (1) that schizophrenia is an abnormal reaction pattern originating in early life; and (2) that the disorder is an organically determined condition of

unknown cause and of obscure pathology which predisposes the individual to a breakdown when confronted with the various stresses of life.

The disorder may result from prolonged mental stress in early life, often followed later by exciting factors, and it consists essentially of a dissociation penetrating to various depths in the mind and nervous system. The hypothesis of a dissociation of consciousness will explain many features of dementia praecox. The extension of the association to deeper levels of the central nervous system explains the physical features of catatonia. This dissociation has been found to be physiologically possible both in animals and in man.

Schizophrenia is a syndrome or reaction type that obviously can be precipitated or activated by a large number of different events and situations, all of which seem to indicate that there is a common denominator that either has not yet been discovered or has not been generally accepted as valid. Whatever it is, it predisposes the human organism in such a way that subsequent events prevent him from making an adequate social adjustment.

The modern psychology of schizophrenia has been constructed upon the basis of concepts of Kraepelin, Bleuler, Freud, Jung, and their immediate derivatives or schools of thought. Kraepelin's contributions are well known, as are also those of Bleuler, who approached the problem from the point of view of an organically determined change in the association processes. His main contribution lies in the painstaking evidence he compiled on the psychological determination of the majority of schizophrenic manifestations. Jung, studying the problems from his psychological viewpoint, did not consider the psychic symptoms to be dependent upon association disturbances primarily. For example, he interpreted schizophrenic negativism as an attitude of rejection and not a consequence of interruption in associative processes. Freud's theory of schizophrenia rests basically upon the concept of regression from object relations to the state designated as "narcissism."

In studying any case of schizophrenia, it is evident that a feeling of insecurity has developed in early childhood which has caused a tendency to retreat to positions more secure,

combined with attempts to increase the importance and strength of the personality. Primitive attitudes and methods of defense are adopted, a prominent one being the attitude of indifference, which may culminate later in stupor, catalepsy, automatic obedience, indifference toward pain, and postural tendencies. The schizophrenic may display a diffuse defense against everything that is done for him, as well as at times resort to a violent attack against others. One of the basic attitudes is a diffuse erotic relation to all other persons. The primitive attitudes are also found in the early stages of the ego-ideal development, in the formation of language and thought processes with symbolism, projection, and identification. The primitive threat of destruction is revived by every danger-threatening situation in everyday life, resulting in outbursts of aggressiveness. Many of these primitive motor and other defense reactions seem to be related to organic mechanisms in the central nervous system, although, so far as is now known, they do not reflect gross brain lesions.

A better understanding of schizophrenic psychology may be revealed by more complete studies of patients treated with insulin or convulsive-shock methods. There is no known pathogenesis of schizophrenia as an entity. Therefore, one has to consider each individual subtype reaction separately —an approach that is reinforced by Birnbaum's structure analyses, Kretschmer's multidimensional diagnostics, Bleuler's "Tiefen-psychologie," and other systems of analysis.

The schizophrenias have been grouped in many different ways for purposes of study, in an attempt to segregate the reaction patterns for comparison and special evaluation, and although no classification has been entirely satisfactory, the following four categories are recognized by all clinicians:

1. Nuclear or central group with progressive and finally extreme deterioration.
2. Acute turmoil type (Campbell).
3. Simple deterioration type.
4. Atypical reactions—*e.g.*, affective, pseudoneurotic, and so on.

There are a great many diagnostic blunders in this field, and a further elucidation of the schizophrenias may be effected by carefully organized studies of the outcome.

In schizophrenia the pathogenesis and diagnosis are both actively disputed factors, a fact that makes prognosis difficult to ascertain or even to discuss. The great diversity of the symptoms seen and described in psychiatric clinics and collected under the diagnosis of schizophrenia is difficult to explain unless one assumes that there are large numbers of contributing factors and combinations.

There is evidence of a central group of cases with other cases in marginal situations which can be termed "symptomatic" schizophrenia, and certain acute exogenically determined psychoses. However, one must have some proof of the relationship of exogenic injury, infections, pathological prepsychotic personality factors, and hereditary components, before utilizing etiology as a basis for prognostications. Clinically, it is distinctly advantageous to separate atypical schizophrenic conditions from the main group and give them an identifying description.

Although it is not the purpose of this paper to discuss shock therapy in any detail, since we are now in an era that might be designated as that of shock methods, its relationship to prognosis should be one of the first things mentioned. The discordance in the opinions of recognized experts in the field, based chiefly on inadequate or at least dissimilar research procedures, have left me and probably others also without any answer to the following questions: Does shock therapy cure patients otherwise incurable or only shorten the duration of a schizophrenic illness in patients with a favorable prognosis? Is it the deciding factor in patients of doubtful prognosis? How lasting are the results? Are they more permanent or less so than spontaneous or psychotherapeutic recoveries? Do shock therapies harm the patient? All patients? Or only certain types?

As a background for future attempts to seek information on these questions, the results of numerous studies on what appear to be favorable and unfavorable prognostic elements in the situations of spontaneous recovery and non-recovery in schizophrenia in the pre-shock era are available. The following tabulation of prognostic criteria has been arranged from the accumulated information.

Alleged Favorable Prognostic Criteria

1. Absence of "nuclear" symptoms.
2. Short duration of illness (recoveries are more complete from them).
3. Acute onset:
   a. Catatonic and atypical subtypes of this group (excitement or fixation).
   b. Atypical acute onset:
      (1) With affective components outstanding, resembling depressive or elated states.
      (2) With toxic-delirioid components.
      (3) With alternating states of excitement and stupor (confusion, clouding of consciousness).
4. Obvious exogenic precipitating factors.
5. Extraverted pre-psychotic personality.
6. Pyknic habitus.
7. Previous episodes of a slightly different nature or containing considerable affect.

Certain lines of investigation have shown that some combinations of bodily habits and symptoms in an essentially schizophrenic psychosis favor a good prognosis, while others indicate the opposite, regardless of the type of general or special treatment afforded. Some of these combinations are as follows:

1. Pyknic habitus and cycloid temperament + a presenting affect in the psychosis (particularly depression) = favorable prognosis.

2. Pyknic habitus + cycloid temperament + active exogenic precipitating factors = favorable prognosis.

3. Athletic habitus + schizoid temperament + exogenic precipitating factors and amnesia for the acute phase = favorable prognosis.

4. Asthenic habitus + schizoid temperament = unfavorable prognosis.

5. Asthenic habitus + cycloid temperament = unfavorable prognosis usually.

6. Schizophrenic-like children with poor abilities usually have a poor prognosis, which is true also, as a rule, of "clever" children with a schizoid temperament. The special abilities do not seem to help much.

There are a number of factors that one might call antagonistic to schizophrenia, or at least they tend to interrupt the course of the disorder in various affected individuals. Of these one would mention:

1. Acute infectious diseases, which may also on occasion precipitate an acute attack of schizophrenia.

2. The pyknic-thymic constitution, which is a setting in which schizophrenic disorders have a tendency to recover rather than to regress to the state of vegetative existence.

3. Various "shock" situations, such as (a) physical trauma to the brain, which again may in some instances precipitate the disorder; (b) epileptiform attacks, which were utilized in the theoretical concept by Meduna to explain the action of cardiazol; (c) severe psychic shocks; (d) strangulation from attempted suicide; and (e) agonal states produced by the shock therapies.

It has been fairly universally conceded by those who deliberately use the therapeutic-shock methods that the appearance or revival of the following symptoms in a patient indicates a favorable prognosis, and when they appear during the active course of the treatment, there is rather an expectation of improvements, regardless of the number of comas that have been attained. In this group of symptoms one might mention the apearance of euphoria, syntonic activity, self-analysis and particularly self-criticism, some hysterical states, explosions of excitement with swings to depressive affect, a disappearance of some of the schizophrenic symptoms that have previously been present constantly, and occasionally an accentuation of some of the schizophrenic expressions, thus indicating that the condition has been rendered acute, and therefore more favorable in outcome, because of the better prognosis practically always to be inferred from acute conditions as compared to chronic states.

In the minds of many investigators, there is little doubt but that the high incidence of schizophrenia, as well as of other mental disorders, is due to the various complexities of our civilization. This is by no means an idea limited to modern conceptions, in as much as one can find in many of the older books and articles on psychiatry similar pronouncements in almost exactly the same terms.

Those who very decidedly ascribe mental disorders to our environmental factors seem to ignore rather consistently the basic principles of constitutional medicine. The "ground" pathology must always be included for study in any system

of investigation that seeks for fundamental etiological units. Just as schizophrenia predominates over all other mental disorders in civilized countries, it also does—or at least is outstanding in its frequency—among more primitive peoples —that is, if one is to judge from what observations have been published. There is already enough literature on this matter to lead one to suspect that those who insist upon the rarity of mental disorder among primitive peoples have no intimate acquaintance with these peoples and probably no comprehension of the primitive cultures and their various pathological expressions.

It goes without saying that more investigation is needed among primitive people. It should be the trained psychiatrist's duty to gain a knowledge and understanding of such people because a basic understanding of the mental-disease situation is positively dependent upon psychiatric knowledge and clinical experience with all sorts of behavior problems. Unless one has been well trained and is experienced—in short, knows what to seek and to record—many psychological and psychopathological expressions may escape detection, particularly as they are apt to be hidden in mythological beliefs. Those elements which, in our civilized, convention-ridden minds, represent the freedom that we ascribe to the pagan in his dress, nudity of body, robustness of physique, and so on do not mean that he is an example of psychological well-being.

From one viewpoint, schizophrenic regression can be interpreted as the natural consequence of a deviation in the physiological processes which prevents them either from reaching the destiny of maturity or from maintaining an adult type of adaptation. The different ways in which the schizophrenic person utilizes his libido constitutes one of the outstanding characteristics of the disorder. This regression of the libido is usually well under way at the time the patient comes to the attention of the psychiatrist. It is possible that mental conflicts early in life and traumas are not really causative, but are by-products of the schizophrenic process, which idea could be extended to include a statement to the effect that all psychogenic aspects are by-products of the organism as a whole. A great many pre-psychotic histories indicate that parents

have noticed peculiarities in the development of the child who later becomes a mental patient. They frequently mention ways in which this child differed from the others, and their accounts usually show in no uncertain way the more or less stable fixations to infantile or juvenile stages of development from which the individual is unable to free himself to attain the patterns of adult life.

Some of the productive types of research now under way should receive a special mention:

1. After years of effort and attempts on the part of many workers throughout the world, methods have been established for measuring and controlling the blood to and through the brain in a circulation isolated from the rest of the body. The value of this method is obvious, as now various drugs and substances can be studied as to their effects on the brain tissues without passing them through the systemic circulation with its possible and probable complicating effects and modifications in the reactions. This method, which lends itself to such a wide range of research and problems, was, naturally, worked out on the lower animals, but a number of the findings have been applied to the diseases of human beings and at present the experiment is being extended into the clinical mental field.

2. Outstanding contributions have been made on the way impulses are carried by way of the nerve cells and their extensions. The way nerve impulses are transmitted through the nerve ganglia, the manner in which several chemicals exert their influence on the nerve cells, and the effect of lack of oxygen on the nervous mechanisms, have all been elucidated and certain laws and principles of nervous action have been established.

It has also been found by numerous workers that there are abnormal, but nonspecific, brain waves in the majority of well-developed cases.

3. The effect on behavior of the removal of different parts of the brain of the higher animals experimentally and of man therapeutically, in the various psychosurgical procedures, is being studied thoroughly and important contributions have been made already on such phenomena as "psychic blindness," hallucinations, eidetic imagery, obsessions, and pain sensi-

bility. We may expect to acquire a great deal of basic knowledge of the anatomy and physiology of the various parts of the brain that will aid us in the application and evaluation of several types of therapy.

4. Insulin and other drugs have been used a great deal in the treatment of schizophrenia. They, as well as the more widely used electroshock therapy, are thought to produce certain changes in the brain tissue. To determine such changes in the brain as well as in the rest of the body, many workers have devoted themselves to the study of the constituents of the blood, spinal fluid, urine, and tissue elements of both animal forms and treated human beings. Much of practical value, as well as indications for additional research, has resulted from these efforts.

5. On the basis of the concept that, speaking generally, the earlier in life a disorder or a predisposition thereto can be detected, the better the chance to do something to prevent or to interrupt its course, a truly productive amount of research has been done on schizophrenic or "schizophrenic-like" conditions in children, and it can be said that rather reliable criteria have been established to detect the presence of the disorder at a very early age. It is now generally accepted that schizophrenia is seen in young children, that it can be differentiated from other conditions in a large percentage of cases, and that further research may make it possible to anticipate which individuals are predisposed to develop the disorder later in life.

6. Thanks to the researches carried out by psychologists, we have learned much regarding conceptual thinking, language characteristics, personality construction, and the schizophrenic's performance patterns in the Rorschach test, which is rapidly becoming one of the most useful tools in the laboratory and clinic. From the Rorschach alone it is possible to make a diagnosis of schizophrenia in a large percentage of cases if the study is made by an experienced worker.

7. The familial incidence of schizophrenia definitely is greater than in the general population, but the interpretation of this fact differs among various students of the subject. Some believe it to be entirely a social transmission without any well-controlled evidence, while others attribute it to

straight hereditary transmission, and still others hold that it is a combination of the two sets of forces.

On the basis of genetic investigations of families and a large number of twins affording conclusive data, Kallmann finds the chance of developing a schizophrenic psychosis increases in direct proportion to the degree of consanguinity to a schizophrenic index case. The hypothesis proposed by some workers that this correlation can be explained on nongenetic grounds by assuming a simple correlation of closeness of blood relationship and similarity of environment, is invalid in view of the fact that one-fourth of the monozygotic twin pairs show concordance as to schizophrenia without having had a similar environment, while nearly one-half of the dizygotic pairs remain discordant even when the two twins have been exposed to the very same environment.

Whether an active psychosis will develop in the predisposed person generally depends upon an interplay of constitutional and environmental factors. A deeper knowledge of genetic agents will lead to improved methods of treatment and prevention, and the genetic factor may well be the common denominator in the schizophrenic process.

It is possible that the schizophrenic is a special type of "person," with all that this implies in terms of heredity, biological organization, developmental patterns, and personality reactions with subtypes. Should this be true, "schizophrenia" could not be considered as a disease except in the social sense of indicating a difficulty of adjustment in society. It may represent a special way of experiencing a totality of events which some of us are unable to define in the light of our present personal knowledge and experiences. To us it appears to be a form of maladjustment characterized by a type of change in feeling and thinking resulting in odd behavior, a specific disorganization of the personality due to the circumstances of life and often terminating in a complete failure to adjust to what is generally accepted as reality.

Although comparisons of results show that there is no specific treatment yet discovered for schizophrenia, active therapy of some sort should be afforded to all patients, since so many of them may be improved and returned to society. Moreover, it usually helps a lot when the patient is in a

therapeutic situation and begins to realize that a serious attempt is being made to cure him.

It is very difficult to consider schizophrenia as an entity with a definite form, function, or special behavior. Students of this subject in the past, as well as many of those in the present day, emphasize first one aspect and then another of the disorder, or perhaps it is better designated as a group of disorders. It is rather easy to start with a general concept of schizophrenia and proceed in almost any direction into its ramifications and relationships. For example, one's attention is easily directed into the subjects of education, euthenics, and eugenics on the one hand, and into pathology and general biology on the other hand. The fields of organic evolution, zoölogy, morphology, ecology, physiology, neurology, endocrinology, physiological chemistry, heredity, embryology, genetics, and biometry, to mention only a few, are among the disciplines and interests that might be developed out of the field of schizophrenia. Many investigators see a larger scope in which to apply knowledge gained from the study of schizophrenia in the types of human activity covered by anthropology, archæology, ethnology, and the social sciences, with an emphasis on its application in criminology, in mental hygiene, and in the worlds of business, industry, invention, and art.

Although the above mentioned fields in themselves include almost everything that is known about human behavior and its effects, the emphasis should perhaps be placed on those parts of the totalities that are subject to organic adjustment and bodily powers, and on the so-called psychological functions, particularly those of consciousness. Because, after all, it is the actual functioning of the mind of man and the determinants of this functioning that constitute the major principle of life and without which there certainly would be no understanding of the rest.

The integration of clinical and laboratory investigation of schizophrenia throughout the country is desirable and even necessary if we are ever to solve this mystery. I do not believe it is unsolvable. It is a practical scientific problem which can be solved by profound thought, patience, and constant toil, with application on a broad front.

Because of the great human suffering involved, the ruination of promising careers, and the blasted hopes that this disorder engenders, the public is sensitive and eager for any news bearing on possibilities of relief. For these reasons, backed by powerful wishes, reports of moderate advances toward the understanding and control of the disorder are often exaggerated, to the extent that any new hopeful lead is mistaken or accepted for a fully developed solution to major problems. Disillusionment and discouragement are bound to follow as the price paid for these exaggerations. Progress reports are of interest and importance when properly presented and interpreted, but they should be balanced by a clear description and indication of the distance ahead that still has to be traveled to reach the goal.

The outlook in research must always be optimistic, and it is no scientific crime to hope that the solution is not far away, but one must also face the facts as they are and rest assured that the problem will be solved eventually through the continued, persistent efforts of those persons whose satisfactions in life are search and research and more research as long as there is anything left that is not understood by the mind of man.

MENTAL ILLNESS AND THE ECONOMIC VALUE OF A MAN*

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WHEN one dies or suffers from a severe disabling illness, there is an emotional response on the part of family, relatives, and friends, the degree of which cannot be measured objectively. There are in addition, however, certain economic consequences over and above those resulting from the costs of medical care. The great majority of men and women are producers, until ill health postpones or ends their productive activities. What we contribute to society, in an economic sense, depends upon individual capacities, but it depends also upon the duration of life. A man who dies well toward the end of the life span leaves a void in the hearts of his family, but before his death he had ceased, in the majority of cases, to be an economic producer. A man who dies in early maturity, on the other hand, will have failed to add his full share to the wealth of family and community.

Thus, from the point of view of the economist, we all have a value, based upon the difference between the expense of upbringing and maintenance and the contributions that we make to the wealth of the nation. Certain diseases that occur relatively early in life, therefore, have a more profound economic consequence than diseases that strike at an advanced age, because the former reduce the number of years during which productive capacity would have compensated for the costs in childhood and early adult life.

From this point of view, mental disease also has profound economic consequences. We know, for example, that mental disease not only shortens life, as is true of many physical diseases, but that it does so at disproportionate rates. Death rates among mental patients are from 2 to 20 times as great as those of the general population of corresponding age.[1]

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[1] See *Mortality Among Patients With Mental Disease*, by Benjamin Malzberg. Utica, N. Y.: State Hospitals Press, 1934. p. 29.

The result is a great reduction in the expectation of life. At age 20, for example, patients in the New York civil state hospitals had an expectation of life of approximately 19 years in 1930, compared with about 40 years in the general population.[1]

In addition to such mortality, however, patients with mental disease suffer long periods of disability. Those who are discharged leave the hospital after an average residence of from five to six years' duration. Finally, many of these patients, even after discharge, do not fully recover their previous capacities as economic producers. It is clear, therefore, that mental disease results in severe economic losses to the community. In the following discussion, we shall refer only to decreased earning capacity, though it must be emphasized that there are other losses, resulting from the necessity for capital expenditures for hospitals and the annual costs of maintenance.

We shall endeavor to estimate the loss in working years due to mental disease, and the present value of the net economic earnings during the working period subsequent to the onset of mental disease. The working period is generally assumed to begin at age 20 and to end at age 65. In recent years the upper limit has been extended in many cases. Therefore, I have assumed that we ought to place the upper limit, on the average, at age 67. Now, if we all lived to age 67, and worked continuously to that period, the working life would extend to 47 years. The average number of such years depends, however, upon the expectation of life. Because no other comparative tables are available, I have used the life tables for total males and females in the United States in 1939–1941.[2] According to these tables, a male aged 15 had an expectation of 51.43 years, but when we consider the expectations of life at the beginning and at the end of the working period, then the expected working period at this age becomes 33.9 years. In a similar way we may estimate the expected working period at each age up to 67. With these we must

[1] See *Social and Biological Aspects of Mental Disease*, by Benjamin Malzberg. Utica, N. Y.: State Hospitals Press, 1940. p. 310.

[2] See U. S. Department of Commerce, Bureau of the Census. Life Tables and Actuarial Tables, 1939–1941. Washington, D. C.: Government Printing Office, 1946. pp. 28–31.

compare the expected number of working years remaining to patients after admission to a mental hospital.

During the fiscal year ended March 31, 1948, there were 9,051 male first admissions to all the state and licensed hospitals for mental disease in New York State. According to the average life-table values for males in the United States from 1939 to 1941, a group of 9,051 males, corresponding in age to these patients, would have an expectation of 134,636 working years. In the case of mental patients, however, such an expectation cannot be realized. As explained previously, mental patients have death rates far in excess of those of the general population, which means a reduction in their expectation of life. In the next place, mental patients spend varying periods in hospitals, and even after discharge their capacity for sustained labor remains unduly affected in many cases. Consequently the expected number of working years for such a group must be less than that for the general population.

In 1928 Dr. H. M. Pollock asked a group of leading psychiatrists in the New York State Department of Mental Hygiene to estimate the per cent of productivity that is lost, on the average, when patients enter a mental hospital.[1] Except for upward revisions with respect to certain functional groups of mental disorders, I have, in general, accepted these estimates as valid to-day. I have, for example, reduced the expected loss in dementia praecox from 75 to 65 per cent. In the manic-depressive psychoses I reduced the expected loss from 45 to 40 per cent. I made these revisions in view of the success that has been obtained through the use of the several types of shock therapies. The corresponding percentages for the remaining groups of mental disorders are shown in Table 1.

During the year ended March 31, 1948, there were 390 first admissions with general paresis. In accordance with life-table values for 1940, a group of males of similar age would have an expectation of 4,899 working years. It is estimated that a first admission with general paresis will lose 70 per

[1] See "Economic Loss on Account of Hospital Cases of Mental Disease and Associated Physical Disorders in New York State, 1928," by Horatio M. Pollock. *Psychiatric Quarterly*, Vol. 3, pp. 186–95, April, 1929.

TABLE 1.—ESTIMATED LOSS OF FUTURE WORKING YEARS AMONG MALE FIRST ADMISSIONS TO ALL STATE AND LICENSED HOSPITALS FOR MENTAL DISEASES IN NEW YORK STATE, YEAR ENDED MARCH 31, 1948

Mental disorders	*Number of first admissions*	*Expected number of working years*	*Estimated loss of working years*		*Average loss of working years*
			Per cent	Total	
General paresis	390	4,899	70	3,429	8.8
With other syphilis of central nervous system	35	397	60	238	6.8
With epidemic encephalitis	19	417	75	313	16.4
With other infectious diseases	23	326	40	130	5.7
Alcoholic	784	10,427	50	5,214	6.7
Due to drugs or other exogenous poisons	31	514	50	257	8.3
Traumatic	112	1,748	50	874	7.8
With cerebral arteriosclerosis	1,690	1,484	85	1,261	0.7
With other disturbances of circulation	53	416	40	166	3.2
With convulsive disorders	140	3,390	85	2,882	20.6
Senile	876	125	95	119	0.1
Involutional	414	3,204	60	1,921	4.6
Due to other metabolic, etc., diseases	32	307	40	123	3.8
Due to new growth	33	213	95	202	6.1
With organic changes of nervous system	66	933	70	653	9.9
Manic-depressive	304	5,636	40	2,254	7.4
Dementia praecox	2,427	62,179	65	40,416	16.7
Paranoia and paranoid conditions	65	636	75	477	7.3
With psychopathic personality	246	6,241	50	3,121	12.7
With mental deficiency	185	4,806	10	481	2.6
Psychoneuroses	494	11,041	40	4,416	8.9
Undiagnosed	68	1,031	60	619	9.1
Without psychosis	457	16,584	40	4,234	9.3
Primary behavior disorders	107	3,685	40	1,474	13.8
Total	9,051	134,636	(56)	75,274	8.3

cent of his productive capacity. Therefore, this group of male paretics will lose a total of 3,429 working years. Similar expectations were obtained for each group, as shown in Table 1, and they result in a total of 75,274 lost working years, or an average loss of 8.3 years per male first admission.

There were 2,427 male first admissions with dementia praecox, and they will suffer a loss of 40,416 working years, or an average of 16.7 years per patient. Male first admissions with psychoses with cerebral arteriosclerosis totaled 1,690, and it is estimated that they will lose 1,261 working years, or an average of only 0.7 years per patient. Male first admissions with senile psychoses also suffered a relatively slight loss of working years, their total loss being 119 years, or an average of 0.1 years per patient.

The average loss in working years is related directly to the average age of the first admissions. Those who enter a mental hospital at age 60 or over have but few working years left. Those who enter at an early age, and with a poor prognosis, will lose many potential working years. For example, male first admissions with psychoses with convulsive disorders totaled only 140, but the average loss of working years amounted to 20.6. Intermediate among those with a high average loss of working years and those with a low average loss were first admissions with an alcoholic psychosis, with an average loss of 6.7 years, and first admissions with manic-depressive psychoses, with an average loss of 7.4 years.

There were 9,356 female first admissions to all state and licensed mental hospitals in New York State during the year ended March 31, 1948. Assuming that their working periods are the same as for males, the corresponding results are shown in Table 2. A group of females with the same age distribution as these patients would have an expectation of 136,232 working years. In acordance with the estimated losses of productive capacity, the patients will lose a total of 77,057 working years, or an average of 8.2 years per patient.

Of the total loss, 43,448 years are attributable to the female first admissions with dementia praecox, 6,687 to those with involutional psychoses, 5,454 to those with manic-depressive psychoses, and 5,361 to those with psychoneuroses. As in the case of the males, the losses in working years are related to

TABLE 2.—ESTIMATED LOSS OF FUTURE WORKING YEARS AMONG FEMALE FIRST ADMISSIONS TO ALL STATE AND LICENSED HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, YEAR ENDED MARCH 31, 1948

Mental disorders	*Number of first admissions*	*Expected number of working years*	*Estimated loss of working years*		*Average loss of working years*
			Per cent	Total	
General paresis	140	2,180	70	1,526	10.9
With other syphilis of central nervous system	18	288	60	173	9.6
With epidemic encephalitis	21	434	75	326	15.5
With other infectious diseases	21	524	40	210	10.0
Alcoholic	268	4,343	50	2,172	8.1
Due to drugs or other exogenous poisons	28	500	50	250	8.9
Traumatic	17	303	50	152	8.9
With cerebral arteriosclerosis	1,486	2,607	85	2,216	1.4
With other disturbances of circulation	52	481	40	192	3.7
With convulsive disorders	110	2,476	85	2,105	19.1
Senile	1,608	252	95	239	0.1
Involutional	990	11,145	60	6,687	6.8
Due to other metabolic, etc., diseases	36	407	40	163	4.5
Due to new growth	25	243	95	231	9.2
With organic changes of nervous system	60	889	70	622	10.4
Manic-depressive	645	13,635	40	5,454	8.4
Dementia praecox	2,624	66,843	65	43,448	16.6
Paranoia and paranoid conditions	64	696	75	522	8.2
With psychopathic personality	141	4,197	50	2,099	14.9
With mental deficiency	176	4,733	10	473	2.7
Psychoneuroses	586	13,402	40	5,361	9.1
Undiagnosed	45	874	60	524	11.6
Without psychosis	156	3,474	40	1,390	8.9
Primary behavior disorders	39	1,306	40	522	13.4
Total	9,356	136,232	(57)	77,057	8.2

TABLE 3.—ESTIMATED LOSS OF NET FUTURE EARNINGS OF FIRST ADMISSIONS TO ALL STATE AND

Mental disorders	MALES			
	Number of first admissions	Estimated value of males of same age	Estimated loss due to mental disease	
			Per cent	Total
General paresis	390	$5,307,489	70	$3,715,242
With other syphilis of central nervous system	35	418,907	60	251,344
With epidemic encephalitis	19	511,994	75	383,996
With other infectious diseases	23	311,832	40	124,733
Alcoholic	784	10,429,583	50	5,214,792
Due to drugs or other exogenous poisons	31	587,230	50	293,615
Traumatic	112	2,076,440	50	1,038,220
With cerebral arteriosclerosis	1,690	1,174,815	85	998,593
With other disturbances of circulation	53	411,820	40	164,728
With convulsive disorders	140	4,267,140	85	3,627,069
Senile	876	43,900	95	41,705
Involutional	414	2,911,168	60	1,746,701
Due to other metabolic, etc., diseases	32	315,520	40	126,208
Due to new growth	33	224,080	95	212,876
With organic changes of nervous system	66	1,083,580	70	758,506
Manic-depressive	304	5,199,548	40	2,079,819
Dementia praecox	2,427	78,088,950	65	50,757,818
Paranoia and paranoid conditions	65	649,720	75	487,289
With psychopathic personality	246	7,844,147	50	3,922,074
With mental deficiency	185	6,074,316	10	607,432
Psychoneuroses	494	13,540,530	40	5,416,212
Undiagnosed	68	1,195,834	60	717,500
Without psychosis	457	13,145,635	40	5,258,254
Primary behavior disorders	107	4,875,376	40	1,950,150
Total	9,051	$160,689,554		$89,894,876

the average age at first admission. Therefore, we find that the average loss of working years amounts to only 1.4 years among female first admissions with psychoses with cerebral arteriosclerosis, and 0.1 years among those with senile psychoses. The average loss of working years was high among first admissions with epidemic encephalitis (15.5), those with psychoses with convulsive disorders (19.1), dementia praecox (16.6), and psychoses with psychopathic personality (14.9 years).

Our next task is to estimate the loss in earnings consequent upon the loss of working years. To do this, it is necessary to have the economic value of a man at stated ages. These

LICENSED HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, YEAR ENDED MARCH 31, 1948

FEMALES					
Average net loss per patient	*Number of first admissions*	*Estimated value of females of same age*	*Estimated loss due to mental disease*		*Average net loss per patient*
			Per cent	Total	
$9,526	140	$1,105,894	70	$774,126	$5,529
7,181	18	148,250	60	88,950	4,942
20,210	21	239,866	75	179,900	8,567
5,423	21	305,116	40	122,046	5,812
6,652	268	2,007,533	50	1,003,767	3,745
9,471	28	270,200	50	135,100	4,825
9,270	17	168,102	50	84,051	4,944
614	1,486	595,504	85	506,178	341
3,108	52	206,354	40	82,542	1,587
25,908	110	1,358,135	85	1,154,415	10,495
476	1,608	36,298	95	34,483	214
4,219	990	4,978,988	60	2,987,393	3,018
3,944	36	188,900	40	75,560	2,099
6,451	25	123,958	95	117,760	4,710
11,493	60	190,157	70	133,110	2,219
6,842	645	7,451,084	40	2,980,434	4,621
20,914	2,624	38,329,360	65	24,914,084	9,495
7,497	64	318,400	75	238,800	3,731
15,943	141	2,532,498	50	1,266,249	8,980
3,283	176	2,775,984	10	277,598	1,577
10,964	586	7,538,775	40	3,015,510	5,146
10,551	45	478,496	60	287,098	6,380
11,506	156	1,968,090	40	787,236	5,046
18,226	39	810,492	40	324,197	8,313
$9,932	9,356	$74,126,434		$41,570,587	$4,443

ages will lie between 20 and 67 years, constituting, on the average, the beginning and the end of the working career. The present values of the net economic value of a man have been computed by Dr. Louis I. Dublin and Dr. Alfred J. Lotka, of the Metropolitan Life Insurance Company.[1] I have assumed for purposes of computation that a man will have a maximum earning power, on the average, of $2,500 per year (after taxes). The resulting data are given in Table 3.

There were, for example, 390 male first admissions with general paresis. The present value of the net earnings of a

[1] See *The Money Value of a Man*, by Louis I. Dublin and Alfred J. Lotka. Revised edition. New York: The Ronald Press, 1946.

comparable group of males would be $5,307,489. Because of high death rates, years of hospitalization, and subsequent further debility, it is estimated that the 370 general paretics will suffer a loss of earnings amounting to $3,715,242, or an average loss of $9,526 per such patients. For the whole group of 9,051 male first admissions there was an estimated net loss of $89,894,876, or an average of $9,932 per patient.

These losses range from $41,705 among the 876 male first admissions with senile psychoses to $50,757,818 among the 2,427 male first admissions with dementia praecox. The average loss of earnings for first admissions range from $476 in the senile group to $25,908 among those with psychoses with convulsive disorders. Other groups with high average losses were: psychoses with epidemic encephalitis, $20,210; dementia praecox, $20,914; psychoses with psychopathic personality, $15,943; and psychoneuroses, $10,964.

In computing the net economic losses among females, it is necessary to make the assumption that their average economic value is half that of a male. This is not unreasonable in view of the fact that a large proportion of the working years of life are devoted by females to activities to which we do not usually assign economic values, though we readily grant the high moral and social values of such contributions. On this basis, a group of 9,356 females, corresponding in age to the female first admissions, would have a total net economic value of $74,126,434. The female first admissions will have a corresponding net value of only $32,555,845, representing a loss of $41,570,587, or an average loss of $4,443 per female first admission.

The highest average loss, amounting to $10,495, occurred among female first admissions with psychoses with convulsive disorders. The largest total loss, however, occurred among the 2,624 female first admissions with dementia praecox, amounting to $24,914,084, or $9,495 per patient. Because of the few working years left to them, the economic loss is small in the case of first admissions with senile psychoses and first admissions with psychoses with cerebral arteriosclerosis.

In conclusion, then, we find that the 9,051 male first admissions to the state and licensed hospitals for mental disease in New York State during the year ended March 31, 1948

will lose 75,274 working years, or an average of 8.3 years per patient. The 9,356 female first admissions will lose 77,057 working years, or an average of 8.2 years per patient. Both groups together will lose 152,331 working years, or an average of 8.3 years per patient. The loss of earnings will amount to a total of $131,465,463.

These data emphasize the importance of expanding both our knowledge of the treatment of mental diseases, and our knowledge as to how to prevent such diseases. Mental hygiene must become an integral part of a comprehensive program of public health. The past decade has witnessed a great advance in the treatment of groups of mental disorders by means of various shock therapies. And it is certain that these procedures have added to the economic value of these patients by enabling them to resume their economic activities, if only for a time.

The great gains will come, however, not by treatment alone, but above all by prevention. In 1931 the estimated net loss of future earnings among male first admissions with general paresis in New York State was placed at $9,500,535.[1] In 1948 the corresponding loss was estimated at only $3,715,242. This great gain was due primarily to the fact that male first admissions with general paresis had decreased from 774 in 1931 to 390 in 1948. This decrease must be attributed to the reduction in the prevalence of syphilis. Should similar success attend our efforts in other directions—if, for example, the efforts of child-guidance clinics should result in an ultimate reduction in the number of cases of dementia praecox—then there will follow a corresponding increase in the economic productivity of a large segment of our population. Let us, therefore, recognize that in the field of mental hygiene, we need ever more light with respect both to the treatment of disease and to its ultimate prevention.

[1] See *Mental Disease and Social Welfare*, by Horatio M. Pollock. Utica, N. Y.: State Hospitals Press, 1941. p. 81.

PSYCHIATRIC FACTORS IN THE REHABILITATION OF THE AGING*

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THE term "psychiatric factors," used in its ordinary medical sense, has a wide meaning in its application to the problems of rehabilitation in the aging. The term also implies the remedial use of many activities and interests that by themselves would not ordinarily be regarded as essentially medical. When we speak of rehabilitation here, we think of attempts at restoring, to his greatest possible degree of efficiency, happiness, and usefulness, a person who has become in some manner disabled after reaching the later period of life.

The management of such problems requires an understanding of the individual's physical, intellectual, and emotional capacities in relation to his adjustment to the world about him. An impairment of this adjustment may be chiefly, or at least partly, responsible for his disability. That is to say that reasonable and realistic attitudes of a person toward accepting the difficulties and limitations imposed by advancing years are very important in minimizing the amount of disability that actually may be present or, what is often more important, in relieving incapacities due essentially to fears. Some older persons are happily able to utilize their capacities and to see advantages inherent in their time of life, while others become fearful, depressed, resentful, and disorganized.

Psychiatric treatment of such conditions is in effect an attempt at rehabilitation. It employs various methods conducive to the encouragement of a healthy personality reorganization and adjustment in the patient. In this effort there is nothing vague or mysterious. The mind is in no sense to be

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considered a fixed object which is either well adjusted, disordered, or treated without reference to the individual's environment. The mind is rather to be thought of as perhaps phylogenetically developed and elaborated to meet the need for a dynamic medium of fine adjustment between the individual and his outside world. If his mind serves efficiently enough for a satisfactory adjustment, a man is considered well. If, for some reason, it fails to a disabling degree, he is considered to have a mental disorder. The contributions furnished by outside activities—occupational, educational, social, recreational, economic, and religious—stimulate the mind to function realistically and are very necessary factors in the personality adjustment and rehabilitation of all people, including those who are aging.

It is obvious that the use of such resources in the treatment of patients is a medical problem. When situations arise that require an alteration of habits or the stimulation of definitely indicated and appropriate interests directed toward rehabilitation, this medical orientation must be practiced. If in such cases an attempt is made to apply general principles, on the basis that what is good for Peter is good for Paul, futility, wastefulness, and even harm may be expected to ensue, since there is then no responsible selection and decision that take into account the individual's needs and abilities.

Many familiar problems occur in the aging that are not essentially psychiatric, but in which psychiatric advice may be desirable because satisfactory progress in the condition has been retarded by hysterical, anxious, hopeless, and other unfavorable mental attitudes. For example, some persons who have developed relatively minor heart conditions have been known to react to their knowledge of this condition by worry, bitterness, and the avoidance of any kind of activity or exercise, however beneficial, withdrawing from almost every association with their friends. We have all known persons who have been made invalids by attitudes that have been of far greater significance than any actual physical disability. In the face of real physical trouble, such as angina or severe arthritis, some elderly persons carry on cheerfully within their limitations, while others feel completely crippled, becoming a burden to their families and friends.

The disabling emotional factors in the latter group can sometimes be greatly alleviated by combined physical and psychiatric attention, enabling the patient to use his reduced capacities to their fullest extent and to secure a reasonable amount of satisfaction in life. Usually it is not necessary in these cases to have the attention of a specialist in internal medicine or psychiatry. The interested general practitioner is in an excellent position to manage these patients in their homes. The doctor, who for a long time has known and had the confidence of the whole family, can do much to disperse the antagonisms that sometimes arise. Strained relationships often exist when the dependent patient uses his condition to gain extra consideration from the family, while his relatives believe that he is not doing his best, but is making himself an unnecessary burden. Such hostility, with the feelings of guilt engendered on both sides, may result in an impasse, with increasing hostility and feelings of guilt, creating a social and therapeutically impossible family situation.

In considering the psychiatric factors in the mental rehabilitation of older people, we should give some thought to the prevention of conditions that lead to personality difficulties and their consequent need for treatment. The maintenance of a good physical condition is of course a very important factor in the promotion of good mental health. Attention to early medical advice may prevent or considerably delay the development of complications in conditions such as cardiovascular disease, which can indirectly predispose to emotional difficulties or may sometimes directly cause mental disorder if the brain should be permanently damaged, as by a stroke. The gradual reduction by the aging person of his exertions and mental responsibilities, to an amount consistent with his capacities, is a very important measure in conserving his health.

Persons vary considerably in their rate of aging, which is always an individual matter. We have used the word "aging" advisedly in this discussion to denote the process of growing old, because it is difficult to know when people are aged in terms of chronological years. Many people are physically and mentally older at sixty than others at seventy-five or eighty years of age. Although it has been said that people

are aging from the time of conception, or at least from the time of full physical growth, we have for practical purposes considered that the later period of life begins at about sixty, since distinct evidences of aging are usually more conspicuous after that time. With the steady extension of the life span and the possible modification of such conditions as arteriosclerosis, we may need to change our conception of aging and regard the older age period as beginning at a much later time. The encouragement of research in the understanding and prevention of the so-called degenerative physical changes that develop in later years has very obvious psychiatric importance. The private and public support of such promising research is imperatively needed.

We are chiefly concerned, in this discussion, with the problems of psychological aging. Psychological aging does not, in the light of our present knowledge, necessarily parallel any apparent physical changes. Attitudes toward life are a very important aspect of aging, some persons remaining intellectually and emotionally fresh, vigorous, and elastic, while others lose their zest at a comparatively early time. Observations show that persons who have no sustaining interests in life after retirement from work are usually the ones who very soon become depressed and disorganized, who go rapidly downhill both physically and mentally, and may soon die. This is true not only in cases of enforced retirement from work, but even when the person has looked forward to a voluntary retirement, but then finds that he has cultivated no avocations, hobbies, or other resources to give meaning and pleasure to living. We have all observed this situation many times.

Increased longevity, with no work, no interests, possible economic insecurity, the gradual dropping out of friends, lonesomeness, and a feeling of not being useful or wanted, would indeed be a bleak prospect. Many useful measures can be taken and a great many either are now being taken or are in progress for the relief of those in such unfortunate situations. The most important measure is of course to help create opportunities for aging persons to help themselves. The trend in favor of a continuation of modified employment, with a gradual transition and tapering off of work, where

possible, is an important factor in the mental health of the aging. Their experience may make them valuable producers to industry and society because of their accumulated wisdom and dependability. Financial aid, which is often necessary, can more adequately be taken care of by further extension of some suitable insurance or pension plan to which the older person has contributed during his productive years. In anticipation of the tremendous increase in our population of older people within the next few years such plans should be established promptly, based upon considerations of adequacy, soundness, permanence, and respectability. There is no way to avoid this problem.

Educational facilities in which older persons can receive instruction and gain skill in new fields is of very great importance. Many already are able to take courses in all kinds of subject, such as literature and painting. This seems to stimulate and satisfy their intellectual and emotional cravings for something to do. Many older persons have spontaneously formed clubs where they can meet, talk, and enjoy other recreations.

When aging persons have reached the time at which they present certain problems to their families, the question often arises whether they would be better off in a home for the aged or in their own homes. The security of the home adds a great deal to the well-being of an older person. He usually likes to be with his family. Whenever this is possible, it is undoubtedly the best policy. Not infrequently, however, the family is reluctant to assume the care of elderly relatives because it interferes with their own activities.

Often families can be helped to understand and to face the conscious as well as the unconscious hostilities that may so easily arise. On the one hand, there is the understandable need of the older members for more attention and participation in the family life, often indeed extending to the point of their trying to direct family activities as they have been accustomed to doing when their children were younger. On the other hand, there is the demand for less interference on the part of the younger members who are now supporting the home. The tension and feeling of guilt that arise on both sides can often be avoided when the situation is better under-

stood and frequently facilities can be arranged at home to prevent this clash.

The solution of the problem sometimes is found in providing accommodations that give more privacy to the older person and in encouraging him to have interests and responsibilities of his own while, at the same time, maintaining him as a member of the family unit. We have probably all seen uncomfortable family situations worked out satisfactorily in this manner. At times, of course, a family may regrettably persist in avoiding their responsibilities. In other cases the older relative is actually too disabled to be taken care of in the ordinary household. Some of these patients may require hospital treatment while others can do well in a suitable home for the aged. The importance of adequate public provision of hospitals and homes is, of course, apparent.

It should be understood that the question whether or not an older person can be taken care of in his home is not always to be decided by a brief conversation with him. It is characteristic of such persons that they may be quite clear on one occasion and very much confused mentally at other times. The same thing is true of memory defects. Old people also may be quarrelsome and even litigious. Some may have confused paranoid episodes in which they believe that others are trying to injure them. When the question arises, the opinion as to whether a person should be accepted for care in a public hospital or should remain at home is and should continue to be a medical opinion, taking into account all the physical, mental, and social facts of the case.

Problems of prevention have to do with the principles of mental hygiene, which promote health, happiness, and efficiency and help to reduce the incidence of mental disorders. Mental conditions, of course, can never be entirely prevented because of constitutional qualities and susceptibilities. Furthermore, in the aging especially, organic disease of the brain is common, often leading to certain inevitable mental disorders. The more persons who live to old age, the more there are who will develop cerebral arteriosclerosis or senile dementia. Many others will develop functional mental disorders, but their number will be much smaller if measures are taken for prevention and early rehabilitation.

At present, however, the treatment and rehabilitation of large numbers of aging persons who have already developed mental disorders is a tremendous individual as well as social problem. Fortunately a great proportion of these patients are found to do well. In 1948, careful examinations were made of the records and follow-up studies of the 365 patients who were sixty years or more of age at the time of their admission to the New York Hospital—Westchester Division, between the years 1936 to 1946.[1] It was found that substantially more than half of these patients had had functional mental illnesses. That is, their mental disorders were due to psychological factors and not dependent on any known disease of the brain. As a group, these patients responded favorably to treatment, many showing complete recovery and ability to return to their work.

Other patients in the old-age group suffered from mental disorders due primarily to organic brain changes, such as those caused by hardening of the arteries or senile degeneration. In the presence of advanced organic brain disease, the patient has very little or no capacity for recovery and may require permanent care because of regressed deteriorated behavior. There were many other patients who had some organic brain impairment associated with the changes of advancing years, but who functioned well enough until some emotional or toxic-infectious condition, such as a physical illness or the use of drugs, upset the limited mental balance. Many of these persons also functioned satisfactorily after treatment. Often, in cases in which both organic and psychological factors were evident, the possible degree of recovery was doubtful until after a period of observation and treatment.

The patients whose illness was of a functional nature, and who might have been expected in many cases to have a definite capacity for recovery, showed significantly, in their ability to improve mentally, the importance of having a reason to get well. Those who had good resources in the way of interests, a certain amount of security, and a favorable

[1] See "The Outlook for Patients Admitted to a Mental Hospital After the Age of Sixty," by Hollis E. Clow. *New York State Journal of Medicine*, Vol. 48, pp. 2357–63, November 1, 1948.

family situation in which they were wanted were far more likely to get well and remain well than those whose situation was less favorable.

These factors favoring recovery suggest that aging persons are not only more likely to get well from mental disorders, but are probably less likely to develop such illnesses, if they are wanted, feel reasonably secure, and have a chance to be engaged in useful activities which stimulate the preservation of their personality organization. Wise social legislation alone, however, much as it contributes in a material way, should not be expected to solve the whole problem of personal interrelationships, and no kind of legislation ever has done so. A desire on the part of families to accept and to care for their aging relatives to their best ability seems to be the most fundamental contribution to security. Provision for a reasonable degree of financial security, consisting of opportunities for remunerative work when possible, privacy, recreation, and aid in meeting other individual needs are essential in maintaining the morale of the aging person. Much real help can be given by sound legislation and the administration of social measures.

Such measures might well be designed and administered in such a constructive way as to discourage the development of an often appealing, but unnecessarily complete reliance on outside support, with a premature return of the aging person to the psychologically immature and infantile patterns of dependency which we are trying to help him avoid. Otherwise, it would seem that there could be no better way to nullify the intended benefits of any good program and demoralize both the aging persons and their families. Nothing can take the place of providing encouragement and proper resources for the aging person to help himself, when he has capacity to do so. Experience has shown that this is the only way in which he can feel useful and satisfied.

BEGINNING SCHOOL GUIDANCE EARLY

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IT is nearly seven years since a special committee of The National Committee for Mental Hygiene first set up a guidance project for young children in a New York City public school.[1] The committee was headed by Mrs. Henry Ittleson, a member of the Executive Committee of The National Committee for Mental Hygiene, whose insight and efforts were responsible both for the project and for the study upon which it was based.

The project, known as the Mental Hygiene Project at Public School 33, Manhattan, has been carried on as a demonstration for the New York City Board of Education, under the professional supervision of Dr. George S. Stevenson, Medical Director of The National Committee for Mental Hygiene, and with the active coöperation of Dr. Benjamin B. Greenberg, Assistant Superintendent of Schools, and a professional advisory committee. Set up at the kindergarten level, and later extended into the first grade, this was an effort to work out practical school techniques for applying mental-hygiene concepts.

In an earlier description of the project,[2] its working premise was stated as follows:

> "The time and the place for giving each child a strong, favorable foundation in school and in social living is at the beginning of his school life. Educators, psychiatrists, psychologists, and sociologists, alike, are agreed upon this. For at this juncture, children of assorted homes, reflecting a variety of living conditions and emphases in handling are funneled into their first common educational experience. It is the ideal time for the school to learn about each new child, his past history, and his present personality structure. With this knowledge, the school curriculum can then be used psychologically to strengthen personality and to develop socially constructive attitudes."

The project was exploratory. It began without a set plan, and developed its methods as it went along and as understand-

[1] See *Mental Hygiene Begins School*, by Evelyn Adlerblum. MENTAL HYGIENE, Vol. 31, pp. 541–55, October, 1947.

[2] *Ibid.*

ing of the school's needs grew. Its full program found it working with children, teachers, and parents. The school was located in an economically unfavored section of the city, with high rates of infant mortality and of tuberculosis. It was estimated that from 50 to 60 per cent of the children came from homes broken by divorce, desertion, and war casualties. This was evident in the tension and emotional difficulties of a large number of its children. There were many foreign-born children and children of recent immigrants, temporarily handicapped by unfamiliarity with the English language. During recent years, the influx of children from Puerto Rico rose until, in the year 1947–48, they made up one-fourth of the school population.

On the other hand, the educational philosophy of the school was favorable, and it continued to improve constantly. Some of this was due to the All-Day Neighborhood School, first established at this school. Through the use of additional group teachers, who also conducted after-school clubs, its work in the arts, block-building, and class trips was integrated with that of the regular classroom for the enrichment of children's learning.

Miss Ruth Gillette Hardy, principal of the school when this program was founded, was an administrator of educational initiative and foresight. Dr. Morris C. Finkel, principal since 1946, has markedly improved every department of the school. He has brought increasing vitality, content, and order into the curriculum, tirelessly working for every innovation that seemed to benefit children. The school has had the services of a social worker from the New York City Bureau of Child Guidance, sometimes on a full-time, more recently on a part-time, basis. The total picture has been that of a busy school, trying to counteract the deprivation of many of its children through an active educational program.

The project began its work with children early in their school career, when it might best facilitate their adjustment and be considered preventive. At this early stage, it assumed a liaison rôle between the home and the school. It tried to understand individual children in the context of their complete lives and to work out ways with their teachers increasingly to meet their needs in the classroom. It was equally con-

cerned with understanding individual teachers and parents, and with being useful and supportive to them. On this orientation it developed its procedures.

Work With the Children.—During the first month of the school year, teachers of the kindergarten and first grade became acquainted with their classes. Meanwhile, the project worker gathered home records and observed in the classrooms. At the end of that time, the teacher of each class and the worker drew up a list of those children who showed a need for some help in adjusting to school, and who might profit by the intimacy of experience in a small group. As time went by, this selection of children was increasingly the choice of the teacher. Teachers gained in discernment and sensitivity to the needs of their children. Also, it was considered important to work with each teacher according to her expressed need, and, therefore, with the children about whom she was concerned.

Children referred to the project for group work were:

1. Overly aggressive children who did not respond easily to teacher handling. In a neighborhood with low living standards and many broken homes, there was a large proportion of disorganized, tense children. Such behavior was also seen in children reacting to sibling rivalry, to overprotection because of illness, and to the extremes of overindulgence and severe handling by parents.

2. Shy children who were not entering into classroom activities. These included children unaccustomed to playing with groups of children, foreign-born children, and others who for various reasons felt insecure and inferior to their peers.

3. "Different" children who were in need of additional observation. Sometimes these were children of high intelligence, whose verbal skill and interests were beyond those of most of the group. Children who had a physical disability or who were intellectually exceptional could be expected to be socially atypical.

As each new child was enrolled in the morning kindergarten or the first grade, the project worker took a developmental home record about him in an interview with his parent. The record gave information about the child's health, growth, and family. Through the use of significant questions, it also

showed something of the mother's way of looking at her child, frequently giving clues as to why a certain child made the kind of adjustment he did. The mother usually was found to be pleased with this interview as evidence of the school's interest in her child.

The group work with children had a dual purpose. Primarily it was intended to serve as a guidance procedure for giving teachers additional understanding of the children they taught. Therefore, the project worked directly with a selected group from each class, gathering concrete observational information about them. This, along with other data, suggested certain curricular approaches.

Play in a small group provided an opportunity to observe the individual child more closely than was possible in the larger classroom. His spontaneity, his relationships with children, his use of materials, and his speech stood out in sharper focus. Through play, children showed many of the ways in which they reacted to their homes and to family experiences. The data were a meaningful adjunct to what the teacher saw, and made a sound basis for coöperation between her and the project worker.

In the second place, the group work was intended to be useful and pleasurable to the child directly. Its atmosphere and materials were conducive to emotional release through play and discussion. The adult worker's rôle was intended to give supportive warmth and acceptance to each child. What the worker did to help children learn skills or techniques for social acceptance was individuated and related to her understanding of him.

During the years, the schedule of group work with children from each class was changed from twice each week to once a week, in order that more classes might be worked with. It was considered more important to work with a greater number of teachers and classes than to give this group experience intensively to a few classes. The group work was usually done with five children from a class, who met for one-hour sessions. This number, arrived at after experimentation, was small enough to permit ample interaction among the children. The odd number often stimulated a shift in grouping, without setting play in pairs as a pattern.

The project room was pleasantly furnished for play, with low tables and chairs, an easel, toys, an adult-sized desk, and chairs. Play materials were kept on low shelves where children could reach them easily. These included housekeeping toys, dolls, dishes, and dress-up clothing. There were transportation toys—such as trucks, trains, and boats—and pitchers, basins, bottles, and funnels for water play. Sand derricks and cranes were near the supply of sand and pebbles. There were also puzzles, books, finger paints, and clay.

The sessions often began with the children and the worker seating themselves to talk. Discussion might begin with an account of an experience of some child—a birthday, a trip, or a holiday. Or it might take off with the "picture-book game." In this the worker used a scrapbook containing an assortment of pictures cut out from magazines and specially selected for content that might draw out of children personal feelings about life situations. Shy children often unfolded on this impersonal plane and got into discussion. It provided the worker with an opportunity to see individual differences in children's information, language, and general feeling. After a brief period of this, cued to the children's interest, they went on to free play.

During this part of the session, it was possible for the worker to observe how individual children expressed interests, the ways they had of establishing themselves with other children and of getting and manipulating toys, their word play, and their asocial or social play. Those items of a child's behavior which were significant were recorded and later added to his personal record.

The worker also gave support to the shy child, either finding quiet ways of drawing him into group relationships or, if he was still adult-centered, of giving him additional attention. With others, who were gaining in resourcefulness, she was more passive. She encouraged free play and yet tried to keep the channel of play constructive or, at least, not threatening to the group. A few basic limits were set.

It was considered important to build self-confidence by giving commendation for effort. By pointing up positive assets and showing regard for each child, the worker helped the unpopular child to gain status in the eyes of the group.

Tactile and dramatic play were encouraged, and the room's general tone was conducive to natural speech and laughter.

In general, the worker demonstrated a kind of individualized handling of children like that of a skilled teacher. The teachers periodically observed these group sessions, and it was believed that they took away certain elements of self-guidance. No teacher can be expected to do with a large class what one can do with five children, yet certain attitudes may be similar in both places: the understanding of cause and effect in behavior and the acceptance of each child as a worthwhile human being.

This group work was also helpful in spotting early those children whose behavior already indicated a degree of unhappiness and disturbance requiring psychiatric diagnosis and treatment. These cases were referred to the psychiatric social worker of the bureau of child guidance. The project worker made available her recorded data about such children and attempted to support the recommendations of the bureau.

Work With Teachers.—Regular individual conferences were held with classroom teachers to discuss children with whom the project worked. In considering a particular child, the findings of the group sessions, the home record, observations on his behavior in the classroom, and any test data were shared by the teacher and the worker. They pooled their observations, evaluated them, and planned ways to use the curriculum of the class for the child's good.

These half-hour conferences, held every other week in the project room, were adapted to the teacher's interest. A conference might cover several children, or might intensively consider one or two children. Teachers also examined and discussed home records of other children in their classes, frequently contributing information about them gathered from the classroom.

Teachers were, on the whole, responsive and coöperative toward this conference method. It is felt this was so for the following reasons:

1. The project did not trespass on the teacher's rightful domain as expert in the classroom, nor was its approach generalized. Instead, it worked with a teacher's children and gave her information that was specifically related to them

and to planning curricular steps on a realistic basis. The teacher's carry-over of this individualized approach to the curriculum also benefited the rest of her class.

2. It gave the teacher a time outside the classroom when she might talk about teaching problems with some one not in a supervisory position. At such times she informally discussed an educational pamphlet or course, or welcomed suggestions about handling a particular problem. Here her natural out-of-classroom personality sometimes emerged, enabling the worker the better to understand and to influence her thinking. Her special abilities or interests might be utilized in planning for the class.

3. The project gave the teacher some relief with children who caused her anxiety. This was the kind of specific help she wanted, and it predisposed her favorably toward accepting other recommendations.

At the end of the school year, the worker made up a brief summary about each child with whom she had worked. A copy of this was given to the teacher of the next grade. Another copy was filed in the principal's office. This summary gave a short description of the child's general development, his family, and his abilities as seen by the project. It pointed out his positive learning assets and suggested ways in which they might be utilized in the classroom to stimulate further learning.

As an experimental program, the project went through various stages of growth and change during a seven-year period. Certain techniques were introduced and kept. Others, like the use of tactile materials which were considered an innovation in this school six years ago, were later used as a regular part of the city system's curriculum for young children. Still others were taken over by the school's administrative department.

In the project's early years, when the program for the lower grades was in a transitional state, its worker made arrangements for teachers to visit other selected schools where they might observe different teaching methods. The administrators continued this practice and improved upon it with school demonstration lessons. When the new program for the first grade was introduced, the project supplemented the

temporary lack of materials in the classrooms by compiling a list of low-cost and free materials. The worker gave a course for teachers on "The New Program for the First Grade" and participated in another on "Mental Hygiene in the Classroom."

Interdepartmental Relationships.—Because this project was interested in every school activity that affected the child, it naturally worked with the various school departments dealing with curriculum, health, and social work. The worker participated in curricular conferences for teachers of the lower grades as well as in the general staff meetings. In its early years, the project also set up luncheon conferences with the teachers of the neighboring settlement house, Hudson Guild, which shares the day care of many children whose mothers are employed.

The worker conferred about individual children with the social worker, the nurse, and school administrators. During the past year, the principal established the school guidance service as a regular monthly conference which these workers attended. Specific children were considered here, and the various workers undertook assignments to aid them. The worker also attended conferences about project children at the bureau of child guidance.

Work With Parents.—The project's first contact with parents, usually mothers, was when they came to give home records about their children. They were assured of the school's interest and were told that they might be sent for at some later time to compare notes on their child's progress. Most parents welcomed this attention. Mothers at work could not, of course, come to school except for emergency matters.

In 1947, a parents' hour consultation service was initiated by the project at the school's request. This was felt to be needed particularly because the social worker's schedule had been reduced. The parents' hour was a time set aside each week when individual parents might come to discuss their children. The project room was an "open door" through which parents might feel free to come, without taking administrative time, to air their concern about a child's adjustment, to get child development information and reading materials, and to talk generally.

This service did not undertake counseling of parents. Those who showed such a need, and who were ready to receive help, were referred to the social worker or to other appropriate treatment agencies. The project concerned itself with the school's rôle. It was helpful in matters involving grade placement, in getting psychometric testing done, and in expediting parent-teacher relationships. Some mothers came merely to get specific pointers on the home handling of a situation or to be reassured that their child was "like the others." The worker tried not to replace the teacher's relationships to the parent, but to support and assist it.

Following up Children.—In 1947–1948, the mental-hygiene project, which had hitherto been a three-day-a-week program, became a full-time service. It then initiated a regular system of following up each year the school adjustment of those children with whom it had worked. Individual questionnaires about children were devised and used in interviews between the worker and the child's present teacher. In this way the project extended its support of each child into the upper grades.

This follow-up plan gave the school a running picture of a child's school career over a period of years. It furnished the child's present teacher with an opportunity to raise questions about his history and to relate the old to the new, in understanding him better. In some cases it revealed specific attitudes of a child that required further investigation and attention. The school administrators, working coöperatively, looked into these matters. They reconsidered classroom placement, saw particular parents, and used other community agencies and resources.

Training of a Worker.—After four years of its demonstration, the mental-hygiene project was ready to try out another step. It had produced a certain coördinated plan for working with the regular school program. It now wished to train some one of the school personnel to carry it out. On the basis of its experience, it was concluded that the person who could best understand the orbit of the classroom, and what it was feasible for teachers to undertake, was another teacher. We wished to train a teacher selected on the basis of her personality qualifications of good relationships with children and

adults, comprehension of curriculum, and interest in guidance work. Personal warmth and flexibility were basic requirements; specific educational and psychological techniques could be learned.

Such a request was made to the board of education. In February, 1948, Dr. William Jansen, Superintendent of Schools, assigned Mrs. Evelyn Anderson, a first-grade teacher from this school, to the mental-hygiene project as an assistant, to be trained. The training program for her was threefold. It included (1) apprenticeship and practice in all project procedures; (2) a related program of academic training at a university; and (3) a reading program related to her experience.

As the trainee's experience gave her increased confidence and professional skill, her responsibilities were extended, until by 1950 she was carrying out the project program with a minimal amount of direction.

CONCLUSIONS

In appraising the work of this project as a school-guidance technique, the following points stand out:

1. It provides the school with an induction service for young children that is sensitive to their natural differences (socio-economic, family, and individual) and takes account of these in the school program. Its emphasis is positive and preventive, rather than in the realm of maladjustment and therapy.

2. It sets up a natural opportunity to work with teachers by keeping the focus of collaboration on the particular children in whom they are most interested, the children of their classes. The project's experience indicates that a teacher will usually work more closely with a person or a technique that faces her specific problem with her. Study groups and courses mean more when they have this direct grounding.

3. As a plan that works with children, teachers, parents, and other personnel, it offers a guidance resource to the school that is diversified in its approach, flexible to changes in the school's daily life, and abreast of current problems.

4. From the standpoint of personnel, it is an economical service, requiring only one worker to carry out its program.

5. When the work of such a project is effective, its influence is subtle and quiet. Its achievements in a school are greatest when the persons involved develop favorable attitudes and resourcefulness with seeming independence—without a feeling that they have been worked upon or reformed. No "before" and "after" results can be charted. To attempt to do this is to hurt the spontaneous rapport of the school staff upon which the effectiveness of guidance depends.

This kind of laboratory project can also be used advantageously in the training of new teachers. University training centers, with their increasing emphasis on mental hygiene, are constantly trying to correlate new findings on education and child development with current school practices. Often there is a considerable gap between the theoretical preparation their students receive and the practical conditions in schools for which they are being prepared.

The mental-hygiene project has worked with student teachers, enabling them to follow children whom they saw in the classroom into the project room and to observe them more intensively in small group sessions; to discuss their behavior and their histories with the worker; and to raise questions about them. The project's experience indicates that this is the kind of "live" demonstration teaching that students want and can grasp readily. There should be more of it. It fuses together understanding of child development, curriculum, the community, and the family. It can be used to point up the teaching of students to develop methods in all these areas.

We are concerned with making the teaching profession attractive to more persons and with instilling in them an understanding of the over-all mental-hygiene concept of education. At this time, therefore, the mental-hygiene project is carrying its findings and an interpretation of its techniques into the field of teacher training at a university. Most of the school guidance of children is done by teachers in classrooms, not by outside specialists. It is, therefore, desirable that new teachers be given useful and realistic guidance information and be trained to apply this in their professional rôles.

A REPORT FROM A SCHOOL FOR EMOTIONALLY DISTURBED CHILDREN

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ANY one who has worked in mental-hygiene services recalls children who remain out of school for long periods, either because they are afraid to go to school at all or because they are so troublesome to the school that they have to be excluded. It is not known how large this group is for the country as a whole; there must be many thousands of such children. Undoubtedly there is a much larger group of children who need special education because of emotional inability to take the usual kind of educational program, but who straggle through the educational system, making poor use of it and being a source of difficulty to the school group.

This paper grows out of our experience with a small group-therapy center for emotionally disturbed children. We shall not attempt here to discuss the administrative problems involved in operating such a center, problems that are legion, but merely to share some of our thinking about its therapeutic values, using as a basis for discussion the histories of three youngsters who have been part of the center.

For the most part, the children who are part of the group-therapy project and their parents think of the center as a school. They come during the usual school hours. They do the things, only more so, that children do in a progressive school—they paint, color, work in the shop, sing, dance, have pets and their babies that they care for, swings and huts that they build, to mention only a few of the things that they do. They go on trips and excursions. Some sustained projects, such as the construction of a play house and its grounds or the building of a miniature village are usually carried on in order that the children may gain a sense of their ability

jointly to create a structure of considerable importance. They are helped in their shop work to make small things to take home, symbols again of their ability to be productive. Facilities for formal education are there for them when they are able to apply themselves to this kind of learning.

The teachers are warm, sympathetic people who, through their training and the supervision that they receive on the job, have understanding of the emotional needs of this disturbed group of children. There is one young man on the staff who is primarily responsible for the more rough-and-tumble outdoor play as well as for the shop work with the older children. The kind of program that the staff develops with the children is essentially like that found in any good group-therapy center. Each child is receiving psychiatric supervision, so that the teachers and the other staff members working with the child and his family may have the benefit of psychiatric consultation to help them in their work with the children. The general program planning is the responsibility of the director.

The center makes available to a child and his family an integrated program of services. The child, while a member of the group-therapy project, can have the benefit of education geared to his needs; he can be having, if necessary, individual play therapy, and his parents are usually coming to the center simultaneously for counseling unless they are under the care of a psychiatrist.

Formerly, much psychotherapy with children consisted of work with the parent; often we scarcely knew the child involved. We worked upon the assumption that the child's behavior had been caused by the handling received from the parents and that the behavior would change as and if the parents changed. We realize now that the child's behavior is his particular method of handling or adjusting to his environment. Parental handling influences the behavior profoundly, but it is influenced, too, by constitutional factors and environmental factors outside of the home and sometimes by the chance interplay of these factors. By the time a child reaches a guidance center, his behavior is a complex of conscious and unconscious motivation which for the child has become his way of dealing with his world. His behavior

affects the whole family constellation of which he is a part. With this understanding, we have turned more and more to therapy that involves both parents and children, with more emphasis upon the one or the other as the situation indicates.

But problem situations often yield to psychotherapy slowly. Sometimes it is many weeks before we understand enough about the problems involved to know in which direction psychotherapy lies. Thus we have in instances resorted to institutional or foster-home care for a child in our efforts, first, to understand his behavior and, secondly, to modify it.

The therapeutic possibilities of schools, or perhaps eventually special classes within regular school set-ups, for emotionally disturbed children of normal intelligence seem to us very exciting, based upon our experience. First, such a set-up gives us about thirty hours a week to observe a child's behavior first-hand, and in more varied situations than is possible in a play-therapy situation alone. Of course we have often used school reports to broaden our diagnostic understanding of children's problems, but such second-hand reports have limited value.

Secondly, we have a child in an environment that we can modify to meet his needs for a substantial part of his day. For most of the disturbed children who come to us, we open up a whole new world. The therapeutic possibilities open to them are not limited to a few hours a week. Our children, in coming to the school, are not singled out in the community as different. They do as other children do, but they are removed from the former school situation which, in many instances, they have made into a problem situation for themselves. Without this school for disturbed children, the child is forced to remain in his former school where he often loses ground as he is faced with his inability to be part of a school group. He may leave school entirely and thus be cut off from the opportunities that school can offer. Excluded from school, he is thrown upon the home situation which helped to create his difficulties. Thus the individual psychotherapy with the child and his parents becomes more difficult because the people involved are immersed for twenty-four hours of the day in the situation that has fostered their difficulties.

A discussion of some of the children who have come to the school will point up the interrelationship of the various aspects of the program and how it helps to move the child into normal or near-normal activity.

Charles, aged eight, was referred by a psychiatrist because he was unable to go to school. Faced with going, he became panicky and sometimes vomited. There had been a gradual onset of the symptoms during the year preceding and several incidents of panic during the summer. With the start of the new academic year, he had been entirely unable to enter school. The psychiatrist felt that the problem was a serious one and that the boy should not be allowed to slip away from school and from the contacts with people that school represented.

Through interviews with the parents, we came to understand something of the etiology of Charles's difficulties. The parents are drab people who make shallow contacts. Although they are intelligent and comfortable financially, they rarely have any social life because of their pattern of spending hours each evening in putting Charles and his younger sibling, aged four, to bed. The basis of the problem with Charles seems to be that he has no strong adults with whom to identify. His parents, and particularly his mother, are unable to give force or strength to their relationship with Charles.

During the course of eight interviews with the mother, extending over a period of three months, she made some progress. She gained a limited kind of insight into some of the causes of the problem. She and her husband launched upon a few social activities; she was helped to meet the reality difficulties of getting Charles to school during his recurrent spells of panic. Interestingly enough, therapy with the mother was more helpful in relation to the symptomatology of the younger sibling, who was suffering from frequent asthmatic attacks. The mother was able to give this child much more freedom and eventually to enroll him in a nursery school. There has been marked improvement in his asthma.

The mother began group therapy after three months of individual therapy because it was felt that work with a group might be more helpful to her. In the group she gained support for her efforts to be more forceful and direct in her

handling of Charles. As we evaluate the results of about seven months of work with her, we see that movement on her part has been slow, as one would have predicted, but that she has made progress.

For several months Charles has been able to come to school every day for a full day's program with only occasional and passing evidences of the former symptoms. We realize that he can come only because the school environment is controlled for him. We see him as a weak, empty, affectless child who is easily influenced by the other children. Although he is an intelligent boy and able with his academic work, his free play is childish.

He began individual play therapy when the psychiatrist felt that he was ready for it after a month at school. Although he makes very little use of his time with the therapist, she is important to him, as evidenced by the fact that it is she who can help him when he arrives at a crisis in coming to school.

We are dealing here with a difficult and serious situation. This child has a tenuous hold on the world and any loosening of the hold would be highly dangerous. Hence the fact that he has been able to retain his present level of adjustment is an achievement. The road ahead is a long, uphill one.

Billy, aged six, is a very different boy from Charles. He came to us from the first grade in a country day school where the groups are small and effort is made to individualize the children and to give them an enriching program. The psychiatrist felt that he should continue in this school if possible. In school he became wild and uncontrollable and could not remain with the group. Similar behavior manifested itself at home where, according to his mother, he would yell and dance up and down if anything went wrong. The mother, who had tried desperately for years to convince herself that her son was not different from other children, wanted to have him remain in the school where he was enrolled. Thus the contact was initiated for therapy and counseling. But after three weeks, during which time Billy's behavior at school became more and more troublesome, the parents were ready to enter him in the center for the full-day program.

As soon as we began working with Billy in the group-

therapy project, we gained a different picture of the nature and extent of his difficulties. He was unable to relate himself to a group. He would on occasion become entirely out of touch with the group, and if anything disturbed him while he was in one of these dreamy states, he would begin to yell and dance up and down. Thus we could not have Billy remain with the group in which he had originally been placed. We transferred him to a group with four other children, who in most respects were not so far advanced as he and who thus constituted no threat to him.

Through experimentation, we learned that upsets could be forstalled if he could be kept in touch constantly with the activities of the group. We soon saw how much he needed to be held and in general kept in touch with people through physical contact. We quickly understood why the mother's very conscientious attempts to help him have friends in the neighborhood were unsuccessful—this child was too disturbed to be ready for it. We were able to give the mother some suggestions, based upon our experience, that did help her in preventing some of the spells of upset that were so disrupting to the household. Conferences with the psychiatrist gave us a better understanding diagnostically of the family's contribution to Billy's difficulties and led us into an approach that was helpful to the mother. In addition to the group therapy, Billy had individual play therapy.

After three months of therapy, we observed improvement. Billy's spells of upset became less frequent at home, and there were evidences of growing warmth in the relationship between the mother and the child. We decided to move Billy into a slightly larger group that made more use of the grounds and equipment. The change precipitated a renewal of more acute symptoms. Particularly interesting was the fact that he slipped back markedly in the skill that he exhibited in his painting.

In a few weeks, however, he began to adjust to the new group and the new teacher. His painting, always a popular activity with him, improved in quality and he began once again a steady, though slow, improvement in his behavior. Several months after this change in teachers, his teacher was ill for several weeks and his group had a substitute.

Significant of Billy's improvement was the fact that he did not again slip markedly in his behavior or in his painting.

Billy has a terrific fear of failure and a concomitant need to be perfect. This continues to be a terrific block to his total learning process. Although we know that he is above average in intelligence, he was for a long time unwilling to attempt academic work at all. His fears in this area still retard his learning, although he is gradually making progress. Along with these fears there is a pronounced competitiveness which manifests itself in all his relationships and makes learning uncomfortable for him.

The individual play-therapy sessions with Billy have been fruitful. From the beginning he liked to come, but entered only slowly into a relationship with the therapist, not wanting to accept help from her nor the candy that she offered. By the fourth session there was evidence of a growing relationship, but the fear of making mistakes was pervasive. Billy entered into a phase of symbolic interest during which he collected Statues of Liberty, one of which he wanted near him as he worked. He built ladders, elevators, and lanterns. Gradually in the sessions he has come to work more and more independently and to be content with a less perfect product that he makes himself.

By the end of his first year in school, there is general improvement in all of Billy's behavior. Most indicative, perhaps, is the fact that he is gradually finding acceptance in the group and gradually becoming able to fight back. When he came to us, he was so fearful that he might harm some one that he was literally helpless in the group. He is still, however, having difficulty in making contacts with children in the neighborhood. He is less afraid of failure and is undertaking academic work with more and more interest. He now greets people in a friendly way and is making general improvement in his behavior at home. We look forward to a longer period at the therapy center for him during which he can integrate the progress that he has made, then to the day when he can return to a school for normal children.

We have described two children who needed long periods of treatment at the center, but we envisage the program as especially useful when the problem is such that short periods

of intensive treatment reduce the symptoms to the point where the child can return to a school for normal children, continuing perhaps with less intensive treatment at the center.

Peter is such a child. He was about to be expelled from first grade at a public school when his parents brought him to us because of his aggressive behavior. An attractive, likable child, he fitted easily into our group on his trial visits to us, and we felt at first that he might be helped sufficiently by coming merely for after-school work with us, particularly in view of the fact that he wanted to remain in his school. We found after a few weeks that such a plan was unworkable. The contrast in the two different methods of handling him was so great that he was confused rather than helped. He liked our school so well by this time that he was very little threatened by leaving his former school, though he wanted reassurance that he had not been "put out" and that the people there liked him.

It was only as he felt more secure with us and began to sense the difference in the setting that the former symptoms appeared and in exaggerated form. In the individual play therapy he quickly gave expression to his hostile feelings toward his younger sister and at this same time his behavior became more and more wild and aggressive in the group. As he found the group leaders kindly and accepting, but firm in the limits that they set, he let down the barriers and showed himself to the therapist as the frightened little boy, in need of love and tenderness, that he is. He is a child with many assets whom the other children and the people in the neighborhood in which he lives like, so we feel quite certain that there will be considerable reintegration of his behavior fairly quickly and that he will soon be ready to move ahead, not into a regimented school program, but into a freer, progressive-school type of program, with some continuation of individual therapy at the center.

The interrelationship between the work with the child and the work with the mother has been particularly interesting. In the initial interviews, the mother seemed diffuse and affectless and the decision was made to work with her in a group. She immediately gained reassurance from the group and also from the fact that Peter very quickly began to be

easier to handle at home. At the point when he was most difficult for us to work with at the center, he was making rapid progress at home. We feel that the core of the family relationships is a sound one. At the expense of over-simplification, we can see diagnostically that the mother and father have both admired and disapproved of Peter's revolt. With a minimum of help from us, the mother has been able to lessen her demands upon the child on the one hand, and to be more forceful in controlling his behavior on the other. We see this as a situation in which a continuing contact with the mother at infrequent intervals will help to prevent further crises and to reinforce the warm and sympathetic relationship that exists between her and Peter.

Peter is a child whose difficult behavior might have yielded to treatment that did not involve placement in a special school. The process would have been a longer one and the possibilities of damage to the child and to the relationship between him and his parents and his neighborhood friends would have been greater. We see many advantages to the more focused treatment he had at our center.

In conclusion, we reëmphasize our conviction that combined group and individual psychotherapy for emotionally disturbed children and their parents in a center that can also offer academic training has exciting possibilities for speeding up the diagnostic and treatment process. In some instances this combination of services makes treatment possible for children in their own homes, whereas under other circumstances placement away from home might be necessary for therapy to be effective. In other instances, it makes possible a continuation of a group experience for children who would otherwise withdraw from group contacts. We hope that there will be much more experimentation with such centers.

GROUP WORK WITH MOTHERS IN A CHILD-DEVELOPMENT CENTER

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GROUP work with mothers who are having particular difficulty in raising their children is an integral part of the services offered at the Child Development Center of the Children's Hospital of the East Bay, Oakland, California. By means of its well-baby conferences and other educational services to parents and children of the pre-school age, the center attempts to prevent those serious disorders in parent-child relations that arise to distort or even permanently cripple the child in all his human relations. Prevention through education is the keynote of the center's policy.

Since parents play so large a part in determining the way a child's development shall go, their education is a necessary part of our program. Group work with mothers is one of the educational methods used, and it is with the nature of this group work that we are concerned here. What goes on in a group and what do we hope to accomplish? How do we try to achieve it, and, after three years of experience, what can we say about the values of this method as a means of education in the field of interpersonal relations?

Most of the parents who come to the center come because they are at an impasse in raising their children. They don't know what the problem is, and they don't see any way out. A few come, not because they see any difficulty, but because they are uneasy and feel they would like to do a better job; they would like to prevent trouble. All come because they want some kind of help. Often, they have first gone elsewhere in their need—to their pediatricians, to another agency, or to friends—and have been referred to the center. Quite a few come directly, having heard of the center from those who have been helped themselves. They come from all over the Bay Area, including San Francisco, and seem to represent a fair

cross section of our population in color, creed, occupation, economic status, and educational levels. In age these people are mostly young parents, for the center deals only with children of the nursery age, from birth through five years.

These parents are a selected group in that they recognize that they are in difficulty, are aware that they can get assistance, and want it. We cannot accept all those who come to us for help. Some present problems so extensive and severe that they require more than we are able to give. Those accepted are those who, at the moment, feel confused, bewildered, unable to carry on by themselves, and who yet are essentially strong and free enough, once they find out where the difficulties lie, to change their ways.

Group work with mothers is only one kind of service available to them in learning to get on their own feet again. It may be that a mother will enter a group immediately, or it may be that individual conferences with a parent consultant is the first step, group work coming later. Or it may be that group and individual work go along together. It depends on where the mother is, in terms of her need at the moment.

The children of mothers who make up a group come to the center also, at the same time as their mothers, for two hours a week. The maximum number in a group, either of mothers or children, is ten. Two well-trained nursery-school teachers make it possible for the children to receive individual guidance as well as the guidance that comes from being in a group. We have found that there is great value both for mother and for child in attending the center together and in sharing the common experience of group membership. Offhand, one would suppose that two hours a week in a nursery school would be of small value to a child. This has proved not to be so. It depends both on what opportunities are available to the child and on his capacity to utilize them under wise guidance.

Let us now consider what goes on in the mothers' group. In the first place, ten mothers meeting with a discussion leader cannot be called a group in the fullest sense of the term. For the first few meetings the relations between the members and the leader are somewhat meager and strained, although each knows that the others are there because they, too, are having trouble. At first, this knowledge does not bring them

together; each one is too much aware of the uniqueness, the peculiarities, of her own individual situation, too burdened with a sense of personal responsibility and guilt, too weighted down by feelings of failure. Of course the extent to which each mother has these feelings varies; but at this point misery does not love company. Such feelings, whatever their degree, tend to make barriers between these women; each feels somewhat alone, somewhat defensive, expecting criticism and condemnation.

Because of their apprehension they tend to relate themselves less to one another than to the leader. Moreover, because they feel defeated to some degree and do not know which way to turn, they tend to fall back to a position reminiscent of their childhood, trying to make the leader a figure of authority, a person who will assume responsibility and tell them what to do. Reinforcing their feeling of dependence and their desire to be told what to do is a common American attitude toward the expert, "who knows." The layman feels a great gulf between him and the expert. Out of this gulf arises a feeling that there is magic in the expert's knowledge. The mothers hope that the leader, as expert, will share her magic with them.[1]

The immediate aim is one of helping these mothers to break through the barriers between one another and of modifying their attitude toward the leader. Of no small assistance is the informal, friendly atmosphere that pervades the center. Housed in two small cottages, it seems like some one's home. The room in which the meetings are held is like a simple living room, and to come there after leaving the children in the pleasant playroom seems to be reassuring. Chairs are set in a circle as far as the furniture permits, and the leader sits as a part of that circle, not outside of it. Mothers who smoke are invited to do so.

To remind you that these mothers feel troubled and want help with their children seems superfluous. However, if we consider what their state of mind implies in terms of educa-

[1] Dr. Ruth Benedict pointed out this relationship of layman and expert in her speech at the Conference of the National Association of Nursery Education in San Francisco, August, 1947.

tional principles, we realize that because they are disturbed, they come to the meetings strongly motivated by deep interest, and such an interest is essential in the learning process. The leader brings this interest into play to modify the authoritarian atmosphere and to begin the dissipation of the barriers between the mothers.

To start with, a few simple remarks are made which bring out the concern these women have in common and the universality of their problems. At the same time, the uniqueness of their individual children is recognized, and this recognition suggests a need for each mother to participate in resolving her problem with the help of all. The suggestion of participation carries with it confidence in the mother on the leader's part, which tends to raise the mother's diminished self-esteem and assurance. The focus, at this point, is on the child, in the parent-child relationship.

The introductory remarks of the leader may run something like this: "Every mother present is having some kind of problem in bringing up her child. We are meeting to discuss these childhood problems which arise so often in our culture. Perhaps, however, it would be easier for every one if we didn't talk about children in general from a theoretical point of view, but got down to business through talking about what each Johnnie and Susie is doing, and what seems to be the matter, so that all of us can put our heads together to see what can best be done."

Each mother is then asked to tell about her child's behavior. The leader asks a mother to start off, one who has appeared to be most articulate and least defensive. She tells her story, perhaps without interruptions, or perhaps the leader or a mother may ask a question. The leader can take notes at this time, with the remark that they will be useful for all to refer to.

Often the effect of this simple procedure is startling in the relief it brings. As each mother speaks, the others listen intently, smiles begin to appear, heads nod, bodies relax, and exclamations are heard: "That's my boy Dick all over!" "I can't make Mary 'go' either." "Spanking doesn't do a thing!" "What did you *do*?" It is not uncommon for mothers to comment after a meeting, "I'm so glad we're

really going to talk about *our* kids. I've read the books, but they don't help a bit when you're in a jam! Besides, Jane just doesn't fit the picture."

No attempt is made during this first meeting to discuss the issues raised. Such concentration of attention at this point would interfere with, or even prevent, the development of community interest and thus halt the growth of group feeling. The chance for each mother in turn to present her situation gives her the sense of a definite position in the group; common experiences begin to create bonds between certain mothers; and each one has a chance to get acquainted with the others as they reveal themselves through talking about their children.

The leader is busy, also, in becoming acquainted; in noting characteristic attitudes and feelings, the ways in which a mother thinks of her child, her implicit premises, assumptions, and values; in trying to draw up a tentative outline of the problem between mother and child. She is always aware at the same time of what is going on between these women, and of how the group is shaping up.

At the end of each mother's story, the leader makes a brief comment which may point up a salient feature, may draw attention to a connection overlooked, and so forth. Sometimes it may be in the form of a question which suggests the need to look more closely in a certain area. Such comments suggest the leader's active participation in what is happening, her capacity to understand, her interest, and her desire to find out *with* the mother where the difficulty lies. The mother gets the sense that there is more to know and wants to look; thereby she feels less stifled, shut-in, stymied; her spirits rise, and she has something to work on.

Sometimes, for some mothers, one meeting seems to have produced a miraculous change; they come back to announce with great enthusiasm that the situation has practically cleared up. This is not as mysterious as it sounds; actually, it is the natural consequence of new perception on the part of the mother and, with it, a change in her way of behaving toward her child. The conditions for this change lie partly in the process just described, partly in the mother's capacity to utilize such an experience to change. She is a flexible

person, we say; which means, in other words, that she can learn from experience. Not infrequently—so little faith have we—one tends to doubt the reality of such rapid change.

Mrs. Smith provides an example. At the first meeting of the group, she seemed very eager, yet bewildered, harassed, hurt, and defeated as she described the behavior of her three-year-old son, who tyrannized over the entire family, getting his way by desperate crying when crossed. No one seemed to be able to withstand his heartbreaking wails. This had been going on for months until both father and mother were at high pitch, snappy and irritable with each other and with the boy, who was withdrawing more and more from his home.

Mrs. Smith spoke with great feeling and freedom about the present state of her home life and brought in much of her own past history to show why she was so disturbed about it. She had suffered unusual privations as a child; her family life had been disrupted and much of her time had been spent in boarding school. Her greatest source of affection and acceptance had been an uncle and aunt who had welcomed her into their home and whose home life had come to represent all that was good.

Mrs. Smith ended her tale with these words, "Tom must not *always* have his own way. It isn't good for him. And yet I cannot *stand* his crying!" The leader said, "I wonder why Tom's crying bothers you so." This was said by way of a comment, not requiring an answer, and then another woman began to describe her child's behavior. Mrs. Smith was an actively interested listener in all that followed, and her occasional comments showed keen insight and ready sympathy.

At the second meeting, when the leader said, "Well, what's been happening since we last met?" Mrs. Smith spoke up:

"You know, that question you asked me last time changed everything. I studied over it for two whole days! Then I *got* it, and Tommie has not had his own way by crying since. I don't mean I've ignored him, but it just doesn't *get* me the way it did before. I could see what I had to do. Was he surprised! But he's lots happier—and aren't we *all*! Queer, isn't it? what one question could do. It was more than that, though. Partly it was telling you all about how unhappy I was about everything, and having people listen like they really

cared. Trying to explain it to you somehow made it different for me, too. I'd never really thought about my being unhappy as a kid and Tommie's crying, until I told you, and you asked that question."

Mothers like Mrs. Smith are exceptional of course. Equally exceptional are those who are so rigid and unsure of themselves that they do not welcome a chance—with help—to explore and find out for themselves where their difficulties lie. Between these exceptions lie other mothers, who may be more or less thrown by the idea that they are not going to have their problems solved for them. Because of past educational experiences, they expect to be passive. Finding their expectations unfulfilled, and with the need for active participation upon them, they may become alarmed and resistive. It may take several meetings and a good deal of encouragement before they feel sure enough to give themselves fully to the learning situation. However, there are always those who enter into discussion eagerly, whose interest and willingness are important forces in creating positive group feeling and individual participation.

All of us have experienced the great relief of talking to some one about a problem that has tried us sorely. Much of that relief comes, we say, from not having to bear it alone any more. To tell another what one feels and thinks is a complex process. Not only does one have to try fairly to represent the situation as one sees it, but one must consider whether one's words will convey this picture to the other fellow. This latter step involves looking at what one says from a standpoint other than one's own. One looks through the other fellow's eyes, so to speak—at least to some extent—and in doing so, objectifies one's own thought. It is no longer private and subjective.

We say in education that in this way thought is clarified through the process of communication. This is true; but by emphasizing clarification, we overlook the enormous importance of the objectivity attained and the change in our perception of the problem. It is this step of objectification that, in part, gives us the sense of relief in talking, and it is literally true that we no longer bear our problem alone. It is equally true, as Mrs. Smith said, that "trying to explain it somehow

makes it different." Her sense of the difference came from objectifying the matter through "explaining it." She had enlarged her view by including ours, and from this vantage point could take a fresh look at what bothered her. Unless she had already undergone this experience, the leader's comment would have been of little consequence, if any.

There are two more important aspects of the first meeting to consider. By the time all the mothers have described their children, the leader should have made up her mind in which direction to guide the next meeting's discussion. Her judgment as to which direction to take rests on the extent to which the mothers are now at ease with one another; what ties are being formed between them; how much community of interest has emerged; how far they have come in sensing their need to take an active part in the solution of their problems; and what changes have taken place in their attitudes toward the leader.

It will be remembered that the focus of attention is on the children rather than on the mothers in the parent-child relationships, and it is likely to remain so for some meetings to come, depending on how fast the mothers develop feelings of confidence, assurance, and security in themselves and toward one another. The leader considers, also, the kinds of problem these mothers have described, and selects one of the common themes that run through all of them. Which theme is selected depends on its suitability to the state of the group —how it can be discussed to promote positive group feelings and at the same time to enlarge each mother's understanding of her child.

Perhaps, for instance, "coercion" will best fit the bill. The leader may say something like this: "In listening to you all talking about your children, it has occurred to me that one theme that has been mentioned again and again is a child's refusal to do this or that. Mrs. Brown, your Susie just *won't* go to the toilet. Mrs. Smith, your Tommie *won't* eat unless you feed him. Mrs. Tucker, Jimmie *won't* come in when you call him. And so on for all of you. Suppose the next time we get together we try to find out some of the reasons for this 'won't.' Meanwhile, at home, keep an eye out for the times when they *do* go along willingly and cheerfully. What

seems to happen to make the difference in these two kinds of situation?"

Often a little more elaboration of this idea by the leader is necessary for some of the mothers. When all are satisfied, the leader takes the final step in closing the meeting, suggesting: "This last fifteen minutes, let's all go to my office and look through the window at what's happening in the playroom. I'm keen to see these kids you've been talking about, and I'll bet you are, too."

During this short period of observation, which is fun and exciting, the leader comments on each child, drawing attention to *what he is doing and how he is doing it,* rather than to his looks or manner or dress. She may say, "Which one is Johnnie? Oh, over there climbing the jungle gym. Look how careful he is in managing that high bar! Did you see how skillfully he shifted his weight then? That's good bodily control for a two-year-old, and isn't he enjoying it!"

This emphasis in observation illustrates in the concrete a way of looking at her child that each mother may pick up to use at home when she tries to discriminate between the times when her child *will* and when he *won't.* The suggested focus of attention is best not made directly; it would tend to self-consciousness; let her learn to do it for herself.

This will not be the only time the mothers observe the children in the playroom. While observation is not regular and prescribed, it may occur for each mother several times or only once. The time when it comes depends on the mother's readiness to utilize the experience most profitably and her child's ability to take her observation without the disruption of his own development.

Each mother goes to observe with some definite idea in mind. Perhaps she wants to see how the teachers handle the infinite variety of situations that arise between them and the children, both her Johnnie and the others. Perhaps she wants to get ideas for Johnnie's equipment in their back yard and so watches his choices in the play yard and the use he makes of them. What can she provide, or Dad make, that will serve the same purpose? And so on. Since each mother observes with an idea in mind, and that idea came to her out of the group discussion, when she returns, the others are eager to

hear what she has found out and the discussion that follows enlarges and deepens her experience, as well as that of the others.

We have previously spoken of objectivity as a consequence of the process of communication. In observation, also, a measure of objectivity is attained. In part, how this happens has been implied in describing how the mother's attention is focused on what her child is doing and how he is doing it, and by the fact that in going to observe, a mother has a definite idea in mind.

Let us consider a little this question of objectivity in observation. In the first place, objectivity does not mean depersonalization, though one often finds the two concepts confused. Perhaps the comments of two mothers combined will define objectivity better than I can. After several periods of watching their children in the playroom, one said, "Why, I never really saw *him* before, we've been so mixed up together!" The other chimed in, "Yes, now I can see him free of *me*, and yet it's funny, we seem to be closer than ever." This second mother indicated in her phrase "closer than ever," that emotion is included in objectivity. When a person or an object becomes depersonalized, we mean that emotion has been withdrawn. Perhaps the two terms are confused because objectivity is associated with thinking, and the concept of thinking has become so narrowed and stereotyped, in this age of retreat from reason, that one hardly dares use it any more.

When a mother begins to see her child as separate from herself, and as a person in his own right, it usually means that she has become more aware of herself in the process. She may not fully recognize it, but evidence of the fact appears in the discussions. She brings out more of how she feels about herself, and not only her feelings about her child. She speaks of how she thinks her *child* feels, rather than what she has expected of him. She brings in bits of her own past history, as well as more meaningful anecdotes from home. Also, this phase is marked by bringing into the discussions talk of political events, religious questions, public education, minority groups, marriage, and how one can get fathers really to be fathers. Her mind has begun to stretch in all directions.

Of course all the mothers do not reach this phase simul-

taneously, and this fact marks a critical point in group activity. The group pattern begins to change from one of unity of effort, of coöperative interchange, and of deep interest in what each of the others thinks and feels, to one in which subgroups begin to form. Roughly speaking, there are usually three subgroups: those who have reached the phase described, those who are on the verge of it, and those who are still groping. The group begins to be in flux, unstable; it has lost a measure of its cohesiveness and focus, through loss of a unified purpose.

In part this has come about because those mothers who have reached the phase of expansive self-assurance experience a tremendous feeling of elation, a new feeling of freedom; they feel as if they could conquer the world; they become assertive, aggressive, and try to dominate the group, vying among themselves. They become argumentative with the leader. The behavior of these assertive mothers actually brings into being the other two groupings, each with its own set of feelings in response. Let us call the assertive mothers Subgroup A; those on the verge, Subgroup B; those still groping, Subgroup C. Those mothers in Group B, since they are closer to the experience of the mothers in Group A, are less likely to suffer than the mothers in Group C. Group C is likely to withdraw, become temporarily unproductive, respond with their former feelings of uncertainty and bewilderment, lose what grip they had for the moment, feel vaguely resentful, and turn to the leader asking for direction more than they have been doing in some time. Their vague resentment, however, forms a bond between them and the mothers in Group B, who are markedly resentful. Group B is not going to be put upon; all their competitive feelings are aroused. One or two may turn to the leader, hoping that she will settle a dispute on their side, but mostly they try to hold their own by themselves.

Let me remind you that this description of groupings and of the feelings expressed is a simplified one. Also, while these feelings are in evidence, they are being expressed in the ways in which the mothers talk about one mother or another. Acrimonious remarks, little hostile digs, are apt to be missed in the heat of the intense feelings accompanying the topics introduced. A visitor dropping into the group might think

—for a while at least—that what was going on was a very interesting discussion about—shall we say?—the state of the nation.

What is the educational aim at this stage, when coöperative interest has changed to competitive, aggressive striving between these subgroups? What does the leader do? For the group to have reached this state of affairs implies that the first aim of dissipating the *initial* barriers of distrust and fear between these women and of modifying their authoritarian attitude toward the leader has been partially achieved. At first they had felt too discouraged and defeated to try to think any longer for themselves, to try to find a way out of their difficulties. They had looked to the leader to tell them what to do.

The leader's task had been not to refuse them, and yet not to accept the responsibility they wanted to relinquish. Leading them to talk of their own children brought reconsideration of their difficulties. As interchange of ideas took place, spirits rose. They gradually built up their confidence through the process of thinking together, while the leader guided their thinking with questions that helped them to make connections overlooked and offered information when lack of it impeded progress in their thinking. Her attitude of friendly acceptance and respect, of genuine interest, and her persistence in taking her place *with* them to find out where the trouble lay, gave the kind of support they were seeking—a support that did not sap their strength by assuming that their temporary feelings of helpless dependency were permanent.

Now, however, the situation has changed. As each mother became familiar with the others, felt that she knew where she stood, and was supported by a feeling of belonging in the group, she brought forth attitudes and practices toward the others that up to then had been held in abeyance. Her conduct at this point revealed characteristics that make for difficulties in interpersonal relations. These difficulties are now apparent in the new patterning of the group. At this point the leader will raise for discussion what has happened to the progress of the group as a whole.

It is easier for her to do this since she has been a true participant in the group experiences and because the mothers

know her to be accepting and friendly toward them. For the leader to permit the mothers of Group A to continue in the course they have been taking would be to refuse to accept the responsibility of the position of leader, and the consequences of such refusal are quite clear to be seen. She can count on the probability that several things have happened outside the group meetings that can be called into play. The increase in expressiveness of the Group A mothers has been felt and responded to by their families and friends. Incidents probably have arisen not too dissimilar to those in the group, and it is not unlikely that these events have held rebuff of some sort, disapproval, or withdrawal. These mothers have not remained untouched by the change in their behavior. How will the leader act? Up to this time she has not assumed outspoken direction of the discussions. Now she does so at the beginning of the next meeting.

"It seems to me our last couple of meetings haven't taken us quite as far as we might have gone in understanding ourselves and the children. Have any of you felt this way, too?" A glance around at the mothers' faces usually finds agreement expressed by one or two at least. The leader continues, "I wonder if it wouldn't be a good thing to see if we can find out why. Has anybody any ideas? What's been going on here, anyway?"

This approach implies acceptance of the mothers, but at the same time expresses feelings of dissatisfaction about the way things have been going. The emphasis is on the consequences to all; there is no hint of personal condemnation; the idea suggested is that if the factors that seem to have deterred progress are discovered, the future course of action may be better insured; and confidence in the group's ability to find them out is implied. The expressed dissatisfaction touches off the feelings of frustration in the mothers both of Group C and of Group B.

Usually, it is a mother from Group B who speaks up. Sometimes her resentment is indirectly expressed: "There has been too much arguing here; nobody else gets a chance to think through anything." Or one may say quite openly, "We've been scrapping like a bunch of kids!" Or one of the mothers in Group A will come forth: "I know what's the

matter with *me*. My husband said I was getting too big for my shoes!" There is sure also to be an expression of self-condemnation and guilt on some one's part: "I shouldn't talk so much all the time!"

Using their own experiences in this particular group as the basis for discussion, the leader helps these mothers to discover principles of coöperative endeavor. What brings a group of people together? How does a group best grow and function? How do the members affect one another? What are the differences and the similarities between our group and a family group? And so on.

The simple comments of dissatisfaction quoted above not only expressed the feelings of these women toward themselves and the leader, but they implied standards and values of personal-social relations that need to be made explicit and examined in the light of the actual group process as it has been experienced. Commonly accepted values, motives, attitudes, and practices are challenged and evaluated in terms of their effects on the group process. Such discussion includes the important moral principle that an individual is held responsible for what he *has done*, in order that he may be more responsive in what he is *going to do*. Clarification of the difference between morals as absolute truth and morals as social values inherent in conduct follows easily.

A few such sessions as this serve as transition to the next phase—that of the mothers' critical evaluation of themselves in relation to their children. During the development of the first phase, while the mothers were working toward recognition and acceptance of their children as persons in their own right, the focus of attention was on the children. These mothers were aware of how *they* felt about their children, yet were little aware of how the *children* might be feeling in return. The prime conflict between mother and child for most of them lay in the child's refusal or inability to behave in a way that would bear out these feelings of theirs about him; he failed to meet their expectations.

Through such simple questions as, "How do you suppose he feels?" or, "How would you feel if some one did that to you? Perhaps he feels somewhat the same way," asked at appropriate times, helped the shadowy figure of the child to

emerge. When expectations violated the *capacity* of the child to act as demanded, the leader supplied the knowledge needed concerning the kind of behavior possible at his stage of growth and development. Such procedures led the mothers eventually to an awareness of the fantastic nature of some of their feelings and expectations. The wonder of it stimulated their next step: Why? When this question could be asked, their children stood before them fairly clear in outline.

At this point the focus of attention shifted; they began to look at themselves and ask, "How did I get to feel this way?" Then came a flood of memories from their pasts. These memories came spontaneously, were called up because these mothers *felt* that there was a connection between their behavior, as they recognized it in the present, and these incidents of their pasts. They began to get a sense of the *continuity* between their past, present, and future. They began to feel the reality of change in themselves as a possibility.

Mrs. Tucker in speaking of her great need to have her house just so and how upset she became when John would not pick up his toys, said musingly, "You know, it makes me think of how my mother always had to pick up after my father. He was forever leaving things around and never could find them. I remember one time when I was five, he asked her to help him find his keys. She was making a cake and had to stop. I'll never forget how mad she was. She really blew her top, slammed the cake pans, and yelled, 'If you don't learn to keep things where they belong, I'll walk out of here and never come back!' " I can still hear her. I was scared and I think he was, too!" Then, softly, as an after-thought, "But she didn't leave us."

The other mothers were impressed by the evident vividness of that memory for her. One said finally, "You sure learned your lesson." Mrs. Tucker was quiet for a moment, and then replied, "Yes, didn't I?" Then she added, "It really isn't important to fuss so over my house."

This incident Mrs. Tucker told us of her childhood illuminated many things we had come to know about her through association in the group. She had been one of the most eager, but one of the most timid, mothers of all, one who wanted most to be told exactly what to do. She seemed literally unable to

act unless she had a rule to go by, and she tried to fit all of her life into these rules. It was a great day when suddenly she burst forth in the group with great excitement, saying, "Why, *I* thought we were all coming here for you *to tell* us what to do. Now I see we came here *to learn*!"

It was the turning point for her. Painfully she struggled to try to find things out for herself, and each discovery brought new self-confidence and less dependence.

We can be sure that in telling that childhood incident, Mrs. Tucker *felt* many more of the connecting links between herself that day and the little girl of yesterday. Is it necessary that she put them all into words? Would it even be possible? The connection she made at the time was the most important one *for her*. To press her to make other connections would violate her integrity as a person. What might have happened to her if some one had said, "Why, you're still scared you'll lose your mother"? Perhaps from this incident she told us, of her mother's rage and threat of leaving, and from seeing the way she behaves in the present, one might say that fear of losing her mother had made her conform to what she thought her mother might expect of her. But would this really be an accurate statement about her to-day? Are we not confusing cause and effect? Could not that early fear of loss, real then from her childish view, have made her come to feel so helpless, so uncertain of herself, that only by conformity and compliance could she feel secure?

To-day we are dealing with a woman who has tried to meet life in this way, but who now is learning that it doesn't bring her the security she has been asking. To-day she *is* a person who tries to conform, who turns to others for direction, but one who also is trying to find self-direction. She is seeking freedom *from* the past in order to be free to face her present and her future. The support she most needs now is help in seeing how past fears no longer apply in her present life. Such a statement as, "You are still scared you'll lose your mother," might make so little sense to her that it would be meaningless; or it might arouse such anxiety that she could lose the self-assurance she has gained; or it might put her so on the defensive that she would revert to her former position of timidity and passivity.

It is much easier for us to see other people clearly than to see ourselves so. At first, in this phase of critical evaluation of themselves, the mothers are apt to pounce on one another. After one or two such experiences, they learn to see that sometimes the things one most dislikes in others are the things one has one's self. They learn to use the sharp perception of a bias to illuminate themselves; they learn that their biases *are* themselves. They soon find out that learning is a personal thing, something one must do for one's self. Here above all, in the realm of self-evaluation, they learn the truth in the old adage: "You can't tell any one anything he doesn't already know."

It is the leader's responsibility to see that the flood of memories of the past do not overwhelm the woman in the present. Usually the process of group membership and participation acts as an unconscious brake. Sometimes, however, a peculiarly apt set of circumstances will break down restraint, and insight comes suddenly, too painful to be handled in the group. Then the leader suggests an individual conference. Such conferences do not substitute for the group work, but are an addition to it. Their purpose is to allow for greater freedom in emotional expression, a more intensive working through of the mother's insight as it relates to her present behavior. The process *à deux* is much the same as in the group as far as the leader's part goes. There is no attempt to probe the past further, but to support the mother through the intensity of her feelings as she clarifies the present from the past and regains a mastery of herself.

Mrs. Clark provides an illustration. She had been oversolicitous with her small daughter to the point where the youngster alternated between rebellion and overdependency. Mrs. Clark had learned to look at her behavior toward Mary from the child's point of view and had begun to wonder why she felt so solicitous. She had discovered that partly it was due to her fear that Mary wouldn't feel loved unless her mother was solicitous.

At this point Mrs. White came into the group. She was a woman with the capacity to talk fluently about her feelings, but with little capacity to feel the reality of what she was talking about. In her second meeting with the group, misled by

the women's freedom in expressing their feelings before one another, she burst forth:

"I just hate my child! If I'd known what a nuisance he was going to be, I'd never have had him. Every one told me how much I was missing by not having a child and I didn't want to lose out on anything, so I had him. I wish I could give him back!"

The group sat frozen and speechless as she went on to describe how disrupted her life had become. She paused, and one mother took over, saying that children sometimes seemed mixed blessings. Mrs. Clark's eyes filled as she murmured, too low to be heard generally, "The poor, poor boy! How he must feel!" The remainder of the meeting she was quiet, preoccupied, her face white and strained. Just before the end she gave a little startled cry and her eyes filled again.

After the meeting the leader approached her, remarking that she seemed very much disturbed over Mrs. White's remarks; would she like to talk with the leader alone? She entered the office, burst into tears, and said that Mrs. White reminded her of a feeling she had had as a little girl—namely, that her mother didn't love her. She spoke in detail of her feelings, recalled illustrative incidents, weeping bitterly. When her emotion was spent, she began to differentiate these incidents, seeing in them other meanings than the blanket feeling of not being loved; distinguishing the little girl's feelings from how her mother might have been feeling. Now as a woman she could look at her childish self from her mother's point of view. As a mother she then realized that her daughter was carrying the burden of her mother's childhood grief expressed in misplaced solicitude.

It is important to keep the focus of attention on the present —to allow a mother to use past memories, as they come to her, for the clarification of her present ways of meeting life. To explore the past merely for the sake of retreating from the present can be only destructive. Yet some mothers love to dwell in the past. They use past events to excuse the characteristics they find in themselves in the present. Their theme is, "What can you expect of poor me? Look what happened!" These events are not memories like that of Mrs. Tucker, and the manner in which they are told shows the difference, a dif-

ference that the group senses. One mother, after hearing such a tale, said, "So what? It doesn't help to cry over spilt milk!" History is always written from the standpoint of the present. Mrs. Tucker was speaking of the present when the memory of her mother's rage and threat came to her. The connection she made, in reconstructing past and present, showed her a possible future: "It really isn't so important to fuss so over my house."

There comes a time in the process of self-evaluation when the mothers as a group become aware most sharply of the tremendous diversity of standards and values held among them. As each had searched herself for what she believed and expected, she had assumed, more or less, that the others felt the same way, or she had been aware only of beliefs and expectations congruent with her own. Then came the full realization that other mothers did not agree, and arguments as to the rightness or wrongness of beliefs and practices were begun.

The leader stepped in to redirect these arguments only after they had gone on long enough for all to realize the great diversity among them. Her task at first is to encourage the expression and clarification of these differences. When these are clear, a simple question changes the direction of the group's thinking: "How do you suppose you people came to feel the way you do about these things?" Out of the descriptions that follow, the leader directs attention to the effect of culture in molding individual beliefs and ideas and uses the heterogeneity of backgrounds in the group for illustration.[1]

[1] A word here concerning the Bay Area as a community is in order, for present social conditions play an important part in bringing these mothers to the center in the first place. The rate of industrialization of the area was forced by the great war industries which sprang up almost overnight. Equally rapid was the growth of the army, navy, and aviation centers. The influx of men in the armed forces with wives and children, of war workers and their families, came at such a pace and in such numbers that their assimilation by the community seemed impossible.

Adding to the confusion of the inadequacies in housing, public transportation, and so on were the war-time restrictions on customary ways of life, the anxieties of war itself, and the threat to the "natives" and the "immigrants" of being overwhelmed by customs and traditions other than their own. Living costs rose to a peak where the Bay Area became, and still is, the highest-cost-of-living center in the country.

With the cessation of war, conditions did not revert to "normal," nor did they improve much as far as physical facilities were concerned. The problem of the

Attention is drawn to the experiences these women have had in living in the Bay Area as a sample of what is going on all over America, and all over the world as well. The question is raised as to how our differences can be handled so as to preserve and develop our relations with one another. What have been the ways each has tried, and what have been the results? Does it help to be aware of or to expect great changes as characteristic of our lives to-day? What does this amount of change do to us as people? What does one have to have to take it? What do we want for ourselves and for our children?

The raising of these broad and general questions in their cultural context marks the last phase of development in the group process. It will be remembered that, in the initial meetings of the group, such general considerations, particularly about children, were discouraged in favor of talk about a particular Johnny or Susie. This was done in part because of a tendency to try to fit the particular child into an expected "norm," a norm built of the mother's own personal predilections, plus a body of knowledge about child development gained from reading and from talk with relatives, friends, and other mothers. General theory about children was used, of course, in group discussion when needed to help understand Johnny's behavior. However, the aim at that time was to help the mother to learn how to size up the difficulties between her and Johnny, and, through solving her immediate

local "melting pot" remains, and now that the incentive of working together to "win the war" is gone, tempers are short, differences between people seem intolerable, distrust is rife, and griping is the order of the day. The housing shortage has forced families with enormous differences in living standards and customs to live side by side or in the same house. Americans feel that young married people should have their own homes separate from the "old folks." For many this is impossible, and one home will include three, sometimes four generations, with in-laws and boarders. While those living under such conditions feel cramped and stifled, there are other young married couples who feel very much alone. They are far away from "home" and feel that they have nobody to whom they can turn for help and understanding. War marriages between men and women of markedly different cultural backgrounds add to the discomfort of the older generation, and in turn to the difficulties in making a marriage between man and wife.

Many of the conditions described here are similar to those of other localities; however, they account in part for a lot of the difficulties we see in parent-child relationships, and explain the heterogeneity of backgrounds of the mothers who attend the center.

difficulty with him, to learn ways of thinking that could help to make their relationship a more wholesome one and possibly prevent future disturbances.

In the last phase of development of the group process, the discussion of broad, general questions gives the leader a chance to see how far each mother has come in this direction, how much aware she is of the changes effected and how they came about. To bring all this to conscious attention is now the leader's aim. Utilizing the group's interest in broader issues of interpersonal relations and culture, she helps the group to abstract and to formuate the principles that have operated in the common group experiences all have had, individually and collectively. Certain aspects of her own participation as leader are included in the discussion. To see the changes, both group and individual, as part of a learning process keeps the discussion on an objective level. Critically to evaluate what has happened, collectively and individually, does not make for self-consciousness at this time, but makes for consciousness of self in relation to others. The focus now is on interpersonal relations.

We have seen how in the first phase of group development the focus of attention was on the child's behavior; then it shifted to the mother's; now attention is focused not only on the *mother-child relationship*, but on the nature of relations between people. There has been a steady growth in learning how to get along with themselves and with others in a group. However, these new ways of conduct are vulnerable unless clearly held in mind, for it is easy to fall back on old habits in moments of unusual stress. These new ways of conduct have been discovered and used; their consequences are apparent; to evaluate them is to strengthen them. The learning of these mothers in the group has been continuous with their life outside the group. This free interplay is revealed in the incidents brought forth for discussion. As one mother said when she came back a year later to visit:

"You'll never know what it meant to me to be in our mothers' group. I've forgotten some of what I was like before I came, but I do remember how much I changed. Did you know some of us still get together once in a while to talk the way we used to talk at the center?"

CLINICAL PROBLEMS COMMON AMONG COLLEGE STUDENTS *

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THE early formative influences of home, school, and neighborhood are largely responsible for the make-up of college freshmen. Yet any weaknesses may be minimized or aggravated by campus or classroom influences, and special strengths may be stunted or nurtured and fortified. Universities, therefore, have a grave responsibility, both to the students and to the country, to discharge their duties with a maximum of effectiveness.

A knowledge of the special emotional problems that may interfere with the training process and the cultivation of stable personalities should assist colleges in their task of developing competent, well-rounded citizens. A few thumbnail sketches of the more common clinical problems, in ordinary descriptive terms, may help to crystallize our impressions.

We all know college students who have a variety of symptoms, such as poor marks, restlessness, poor concentration, sleep disturbances, headaches, intestinal complaints, fears, and other symptoms of anxiety. They represent the common problems.

First, there are those who have chosen a type of course that is over their heads. They are the students who had to study hard in high school to keep up. The first few semesters in college, their courses are studded with failures or near failures. Then they develop fatigue symptoms and depressions. Pressing, drawing headaches and shifting pains may alarm them. They have to be advised to take up simpler or shorter courses because they are not intellectually able enough to keep up with their contemporaries in the harder courses.

* An abstract of this paper was delivered as the introductory speech for the first Round Table on College Mental Hygiene, at the One Hundred and Fifth Annual Meeting of the American Psychiatric Association, Montreal, Canada, May 23, 1949.

There is another group whose parents have always wanted them to excel. These young people, being dutiful, start out by turning in a creditable performance, but the parents are very lukewarm when they receive only C's and a few B's. The next year they work harder and get B's with a few A's. The parents are pleased, but feel that they should be critical in order to spur the children to greater effort. Finally, the children bring home almost all A's, with perhaps one B. One particular father, however, wanted perfection and would say to his children: "I think you can do better than that." Actually these young people have always succeeded, but have acquired the impression that they have failed. They have paralyzing feelings of inferiority, which are a great handicap.

Third, there are the students whom we might call the "detailists." They can't see the woods for the trees. I have in mind a boy who was raised very strictly and who became very dutiful and perfectionistic. He tried to do everything in the manual. In his first year, he had only two major subjects and had time to learn every little detail in his assignments. The next year, in a larger college, he attempted to be as thorough with five major courses. Even the bright students had only time enough to attempt one problem of each type. Soon he was floundering away behind and developed a fatigue state, with headaches and stomach pains. He had to drop out of school for a while to recover and to learn to pick out what was important from what was not. The drive for perfection can become a handicap.

It is difficult to remedy such personality problems and a great deal of guidance and help are needed.

There is a fourth group—the brilliant students who, with no special effort, have been on the honor rolls in high schools. Our college populations are largely drawn from this upper two-fifths of high-school graduation classes. Many could listen in class and learn enough without even "cracking a book." They have never had to develop steady habits of application. They come to college and have more competition and more complicated studies. If they don't rapidly learn to apply themselves, they show up poorly, because colleges are for the most part full of high-school honor students.

These students with superior intellects, who have never

been challenged, do no better than those of mediocre ability with good work habits. Frequently they do less well and become drifters. They say, "The professor does not make the course interesting," or, "I just can't get down to studying." A book is started, but not finished, unless it is especially intriguing. They usually blame the mediocre marks on something else. These are the fritterers, wasting time. They carry five courses—that is, they carry one or two and drag the rest. They sometimes seek psychiatric assistance and have to realize that if they drift along, they will come out at the bottom. The ability to get down and plug has to be developed. At first many are unwilling, almost insulted, that so much effort has to be made.

These students are the potential leaders of the nation. Because their brilliant capacities are not challenged in their formative years, too many become mediocrities. The most efficient remedy probably lies back in the junior and senior high schools. An enriched course of study and balanced, progressive methods of teaching can better prepare them for higher learning.

Fifth, there are capable young people who suffer from anxiety states and "blow up" during examinations. Fear of tests seems to afflict most students and is probably an occupational disease. For some, tests are nightmares. One young woman would study hard and know her subject, but blow up in a panic during the examination. This anxiety was traced back to many hidden unsolved childhood problems. One reason why the anxiety focused on final examinations was a long-standing fear of being unable to please a severe school principal, her father.

Among the emotional problems are some revealing rarities. Classroom education is only part of our preparation for life. The influences of early emotional impressions, often distortions of reality, are frequently revealed. A sophomore had been stuttering since childhood. During treatment he came to realize that he had misunderstood his father's blistering condemnation of any hostile statements. The boy began automatically to stumble over his words, becoming chronically frustrated and angry.

A naïve young woman complained that she felt uncomfort-

ably different from her friends. She said, "The other girls feel things my mother says are naughty. One says, 'When a boy kisses me, it rings a bell and knocks me off my feet.' I never felt like that. There must be something wrong with me." When helped to gain a more natural view of all phases of love relationships, she, too, was able to get a thrill out of an ardent kiss.

One young man was in an amazing quandary. His fingers cramped so that he could not write legibly, especially in an examination. He had, it seemed, been raised very strictly and prudishly. A young instructor, who wrote backhand, had tried to befriend this youth and help him to become more tolerant and at ease. At the same time a young minister, who used a flourishing forehand script, misunderstood and reinforced the handicapping rigidities in the boy's character. When the influence of the instructor predominated, the youth wrote backhand. He used a flourishing forehand when the minister's influence was dominant. When undecided, he could hardly write at all. The immediate solution was the use of a typewriter and permission to take oral examinations. The ultimate remedy involved a softening of the boy's excessive inhibitions.

Sixth, there are the more severe obsessive or compulsive psychoneuroses. One young man could not do the courses in science without making repeated mistakes and becoming much disturbed. It was found that he had a compliant, passive father who in an argument would become flustered and quickly retire. His early impression of his mother was that of a dominant, rather threatening individual, "who would leave me if I didn't do as she said." He remarked, "I wanted my father to control my mother, so then I could follow him and become a man." Even as a small boy, he and his mother had decided what to do with his father's earnings. In a rather prolonged course of treatment, this patient had to free himself of several distortions of attitude of long standing and highly charged with emotion. For example, he had to become more at ease about his fancied idea of pushing his father out of the picture by becoming his mother's major companion.

His intellectual mother had, in some way, become confused with science. Attempts to succeed in science courses, there-

fore, stirred up this childhood mirage about possessing his mother and caused the difficulty in his courses. Finally, after fourteen months of psychotherapy, he was able to correct his childhood misunderstandings and was free to progress in his studies.

Psychotic breakdowns have been rare in our experience and during the last two years could be counted upon the fingers of two hands. Such breakdowns are not especially characteristic of college undergraduates and occur in all groups in society.

In summary, we may say that among the main common clinical problems in college students are the intellectually incompetent, the self-distrustful, the detailists, the frustrated perfectionists, the fritterers, the blow-ups, and those who suffer from anxiety states and serious psychoneuroses.

PAUL O. KOMORA

PAUL O. KOMORA, Administrative Secretary of the New York State Department of Mental Hygiene and formerly Associate Secretary of The National Committee for Mental Hygiene, died in Albany, New York, on July 18, 1950, at the age of fifty-eight. Since 1917, Mr. Komora has made outstanding contributions to mental-health progress as a writer, organizer, editor, and as a trusted friend and collaborator of innumerable workers in the mental-hygiene field.

While on the staff of The National Committee for Mental Hygiene, Paul Komora was editor of the *Mental Hygiene Bulletin* (1928–1932), of the *News Letter* (1931–1940), and of the Notes and Comments Section of MENTAL HYGIENE (1932–1942). He was co-editor of the volume on neuropsychiatry of the *Medical and Surgical History of the United States Army* in the first world war. In 1934, he wrote a 126-page report on "State Hospitals in the Depression." In 1938, he collaborated in a survey of research activities and facilities in public institutions for the mentally ill and the mentally defective in the United States and published a 151-page report. In 1949, he was associated with Dr. Earl Bond in the compilation of a biography of Dr. Thomas W. Salmon, published this year.

This incomplete tabulation of writings and activities fails entirely to give any adequate idea of Paul Komora's unique and strategic rôle in mental-hygiene pioneering. He was the right-hand man of Clifford Beers and of four successive medical directors of The National Committee for Mental Hygiene. With Paul Komora's help, these men, with their colleagues, achieved much in advancing mental health and human welfare. He was with Clifford Beers when the founder of the mental-hygiene movement needed an understanding friend who could share with him his dreams and help to translate those dreams into actualities. He was with Thomas Salmon, the Committee's first medical director, in France during the first world war and helped in organizing base hospitals for the

care of the mentally ill. He also coöperated with Dr. Salmon after the war in efforts to develop suitable hospitals for the care and treatment of "shell-shock" patients, as a result of which the U. S. Veterans Hospitals for the mentally ill were established. He worked with Frankwood Williams, who followed Dr. Salmon as medical director of the National Committee, in the difficult task of getting the coöperation of the press in publishing mental-hygiene material. Up to that time, the press had taken scant notice of the deliberations of mental-hygiene and psychiatric gatherings. Perhaps the pendulum has swung too far; but, at any rate, Paul Komora pioneered the way through the press for a greater measure of public partnership.

The third medical director of the National Committee paid this tribute to Mr. Komora upon his completion of twenty years of work with the organization:

> "You have the satisfaction of knowing that you have played a strategic part in forwarding human progress during these last two decades. One instance of your contribution occurred when you introduced me to Clifford Beers and opened the way for developments in Canada. Indeed, all along the line you have been a pioneering, constructive influence. More than any other man, you have provided ammunition for the rest of us to use for the good of the cause. You have been satisfied to work behind the scenes—never seeking the limelight. And we all realize that it takes a great soul to assume such a rôle. Next to Mr. Beers, you have kept the National Committee going, and going along productive lines. It has been a great privilege to have had the opportunity to be one of your colleagues."

There is no question that Paul Komora was a great mental hygienist. His contribution was not that of a psychiatrist, a psychologist, or a sociologist because he had not been professionally trained in any of these disciplines. His contribution was based upon his intense interest in his fellow men, upon his contagious enthusiasm for mental hygiene as an instrument for human welfare, upon painstaking work with no thought for personal aggrandizement, and upon his magnetic personality and fine mind. Paul Komora represented the salt of the earth. Mental hygiene will go far through the efforts of such unselfish and able souls; and the imprint of Paul Komora's service will act as an inspiration.

CLARENCE M. HINCKS

BOOK REVIEWS

THE ENVELOPE: A STUDY OF THE IMPACT OF THE WORLD UPON THE CHILD. By James S. Plant, M.D. New York: The Commonwealth Fund, 1950. 299 p.

There is a popular idea nowadays that there are two types of psychiatrist—those who are engaged in giving "service" and a sort of special group who are engaged in doing research. Perhaps more in psychiatry than elsewhere, this concept is peculiarly false, because it is so clear in our field that research into pathology can be carried out only if and when a type of rapport exists that can exist only in the therapeutic situation. That the "service" type of rapport can be used for research purposes as well, has been clearly demonstrated in Dr. Plant's life and work. In him, active service in diagnosis and therapy did not block research of the greatest usefulness.

Plant is primarily concerned with the relationship between the individual and the world about him. With a kind of Platonic idealism, Plant conceives that the individual does not see the world as it is, but rather that he sees what of it he can use and what is not too disturbing to him. The "envelope" of the title refers to the "membrane" of variable penetrability which stands between the individual himself and the outside world and selects, according to their meaning, which facts and phenomena shall be effective in the personality function of the individual concerned.

The twenty-one problems Plant has found among the potent forces that make people what they are at any particular moment are results, for the most part, of vectors of internal growth forces and social forces playing upon the individual. Much more than most psychiatric writers, he tends to discuss, not the mechanism within the individual, but rather the forces at work in a particular pattern of adjustment. One wonders whether his colleagues of the first sort might not come nearer his method of approach if they could achieve the broad sociological knowledge that Plant won through his years of intensive study. Plant does not believe in the specificity of symptoms; he admits bafflement at the question why the same stress makes itself apparent in one child as stealing, in another, for example, as homosexuality. Therapeutically, he is concerned with the stress and its alleviation, not with the symptomatic behavior.

The manuscript was published after Dr. Plant's death and we

are told that he had not the opportunity for the "editorial interchange" which usually precedes publication of a book. Had there been opportunity for this, the book would probably have been considerably improved. One bothersome feature, the footnotes, probably would have been considerably ameliorated. The book would be much easier to read had the bibliographical references been collected at the ends of chapters and the footnotes reserved for the many arresting ideas allied to, but not really a part of, the argument. As it is, one is too often disappointed to find the expected footnote only a bibliographical reference.

At times the organization of the material also is difficult to follow; this is probably explained by the fact that at one stage of the book's development it was to have been a three-column juxtaposition of material. When this organization proved impossible, the conversion to continuously flowing material was incomplete.

The book bristles with unsolved problems for research and with penetrating insights into a future science of human biology.

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HOW TO HELP YOUR CHILD IN SCHOOL. By Mary and Lawrence K. Frank. New York: Viking Press, 1950. 368 p.

Not only to help the child in school, but to help parents, Mary and Lawrence K. Frank have brought to the writing of this book their wise personal and professional experience and their deep feeling about human values. It is the approach that is perhaps most significant, reflecting the authors' concept of parent education as "helping parents to realize what the normal processes of personality development are, to understand their relationship with their children, and to become more aware of their own feeling toward the child."

The Franks give "no specific rules and answers," but project with great sensitivity a picture of children and families as they are and what they can mean to one another. We see them, not in the research institute, in the clinic, or in the academic textbook, but growing together, responding to the needs and demands of individual personalities—with love and anger, at good moments and bad.

Basically, we begin to see, parents help the child in school as they help him to meet all life situations, by "a pattern of living which will make him confident in others, confident of his own rights and theirs." The quality of affection, trust, recognition, and respect that he experiences in his own family colors his feelings about himself as being

capable, good, worth while. The prevailing "emotional climate" of the home, rather than the isolated episodes, contributes to the strength and confidence with which the child meets the demands of school, or of life. "People close to one another may show their feelings in various ways from hour to hour, day to day, but in spite of disagreements, upsets, painful moments, they maintain a continuing thread of deep affection and understanding." Understanding of children grows as we become aware of what is helpful or "hurtful" to them, and realize that they behave according to the way they feel and the way they have been treated.

To-day the division of responsibility between school and home is disappearing as the goal of education is viewed as a common one—"all-around happy living for children in their families, in their society, in their future life." Intellectual achievement is no longer the only concern of the school. Curricula are being changed with increasing recognition of the feelings of children, their emotional and social development, the personal relation between teacher and pupil, individual differences, "readiness" for learning, the value of first-hand experiences and of play. Through parent-teacher conferences and closer working together, parents are finding out how the school is or should be providing favorable conditions for learning and growth. They are also beginning to understand that helping the child "involves not only what you as parents do in your own home and how you coöperate with the school and your child's teacher, but also how you participate as a citizen in helping to make your community a good place for *all* children."

This book may well serve as a basis for a comprehensive program for parent-teacher associations. It overflows with material for discussion groups and study courses. It integrates principles and observations about child development and family relations that will further the understanding of teachers and those in other professions who are working with parents and in the school setting. Most of all, the authors' underlying affection and respect for people, their conviction as to the values in family life and personal relationships transmit sorely needed encouragement, and a belief that we can all work things out better in our efforts to live together and to help our children learn to live together.

ZITHA R. TURITZ.

The National Association for Mental Health.

THE ART OF REAL HAPPINESS. By Norman Vincent Peale, D.D. and Smiley Blanton, M.D. New York: Prentice-Hall, 1950. 253 p.

Clergymen and psychiatrists have a mutual responsibility in promoting mental health in the community. This book helps to clarify, both for the lay and for the professional reader, the area in which the disciplines of the ministry and of psychiatry overlap. It reveals how the psychiatrist and the clergyman can work as a team in carrying out short-term psychotherapy.

The Clinic of the Marble Collegiate Church, in New York City, was founded more than ten years ago and the authors of this book state:

> "Each of us, in our own professional work, had long been familiar with the tragedy of those who, with the capacity to stand upright, yet crawled through life on their hands and knees. Despite their wish to move forward joyously, they were tormented with the secret thought, repeated like the ominous ticking of a clock: 'I should have done. . . . I ought not to have done.' With no place to turn for guidance, no ear to listen to their grief, they naturally become filled with panic and with despair. And for such as these the Clinic of the Marble Collegiate Church was established. It originated in our mutual conviction that a new approach was needed to the personal difficulties that beset modern man."

The book is divided into the following ten chapters: *Doorways to a New Life for You; Why Do We Love and Hate at the Same Time?; How Can You Have Peace of Mind?; Relax and Renew Joyous Power; How to Stay Healthy under Pressure; How to Treat Depression and Anxiety; How to Have a Successful Marriage; A Solution for Problem Drinking; Comfort and Understanding for the Bereaved; How to Grow Older Happily.*

There are many references to the Scriptures, and the patient may gain comfort from this wise counsel: "Each morning when you get up, say to yourself, 'My life has started afresh and I thank God for His goodness in giving me a new and happy start in a life which I shall make useful to all those with whom I come in contact.' "

The book emphasizes that it is never too late to find, through faith and prayer, the sources of power that give man security and courage.

A high proportion of the illnesses seen in general medical practice are caused by fear, anger, and guilt, and these three emotions are the great underminers of health. When these emotions are repressed into the unconscious, they rankle and fester and give rise to anxiety and depression and contribute to ailments such as high blood pressure, heart disease, chronic fatigue, ulcers, and many skin disorders.

Many rules of good mental hygiene are outlined:

"1. Accept fully the fact that worry can be a most destructive enemy of the human personality, one of man's greatest plagues.

. . . . . .

"3. To be rid of worries about the past, practice the art of forgetting. Every morning, and every evening, repeat one of the surest aids to mental health, 'FORGETTING THOSE THINGS WHICH ARE BEHIND, AND REACHING FORTH UNTO THOSE THINGS WHICH ARE BEFORE, I PRESS TOWARD THE MARK.'

"4. Practice every day the affirmation of your faith in your future and the world's future. As your affirmation of this, use the hymn line, 'So long thy power hath blest me, sure it still will lead me on.' If you have been watched over in the past by Divine Providence, surely you can count upon the same watchful care in the future.

. . . . . .

"8. Practice trying to empty your mind. Say to yourself, 'I am now emptying my mind of all anxiety, fear, and insecurity.'

"9. Then fill the mind, affirming, 'God is filling my mind with peace, courage, and contentment.'"

The book is adequately illustrated with brief case studies and describes the important techniques both of pastoral therapy and of conventional psychotherapy.

There is an important need for this type of reading for the lay person who has an emotional problem and for whom psychiatric treatment is not available. It encourages the clergy to undertake treatment of many of these problems, particularly where there are religious conflicts, and it also provides the psychiatrist with considerable insight into the techniques of pastoral therapy.

It is a warm, human presentation of the common emotional problems and can be recommended to most patients.

LEO MALETZ.

Lynn, Massachusetts.

OLDER PEOPLE AND THE CHURCH. By Paul B. Maves and J. Lennart Cedarleaf. Nashville: Abington-Cokesbury Press, 1949. 272 p.

This book is an excellent demonstration of the important contribution that competent religious workers can make to the whole field of social relations and mental hygiene. As such, it deserves wide, careful, and thoughtful reading by all whose major concern is the study and care of people, whether as a research project, a program of therapy, or as creative family living. Although the process of aging raises several new problems, it also *accentuates old ones*—and that is why this book is relevant to all age groups.

Much of the clinical material was obtained by Mr. Cedarleaf, who, as an associate minister of a parish, had full responsibility for seventy older people, thirty-five of whom were residents of an institution for the aged. This ministry covered a period of approximately a

year and a half and provided an excellent opportunity to minister in such crises as illness and death.

While much of the statistical data taxes one's interest (at least if one is non-statistically-minded), nevertheless, these data do substantiate again and again the authors' premise of the necessity for intelligent, immediate, and active consideration of our responsibility to older people. It is apparent in the very first section of the book, *Aging and the Church*, that the authors are thoroughly familiar with the surprising number of resources for this particular study.

Chapter 3, *The Aging Process*, is particularly informative. There is much confusion to-day as to what is meant by "old." Too often it is equated with "peculiar," "difficult," "ornery," and so on. Many mistaken notions regarding older people are dealt with constructively in this book, and new insights are provided. The whole aging process is extremely well described, and compensations are wisely mentioned. Frank recognition is given to the *destructive* emotions that, when prolonged, often harm the body.

While the specific frame of reference is the Protestant Church, and the authors' concept of man is, both ethically and in terms of origin, basically Christian, this approach has in no way jeopardized the objectivity so essential to any research. The result is a remarkable blend of social data and genuine concern.

The second section, *Pastoral Care of Older People*, offers some of the best material available on the principles and methods of ministering to individuals. Clinical material is used both to illustrate and to demonstrate. The insights of dynamic psychology are applied. Chapter 7, *A Program of Pastoral Care*, contains excellent, practical suggestions for any religious leader, whether he be priest, rabbi, or minister. Chapter 9, *Principles and Methods of Group Work*, is equally valuable.

The final section of the book, *Social Resources and the Church*, presents some very serious and searching questions. These concern not only the clergy and social scientists, but also economists and politicians. There is no longer time to discuss "prevention"; the problems have left the horizon and are advancing irresistibly toward us. We cannot escape.

Publishers of religious books seldom reveal much imagination and taste in format and typography. This book is no exception. It is fortunate, however, that the price has been kept reasonable. All footnotes are wisely assembled at the end, thus providing a minimum of distraction. There is also a good index.

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ROLLIN J. FAIRBANKS.

THE FAMILY: ITS FUNCTION AND DESTINY. Edited by Ruth Nanda Anshen. New York: Harper and Brothers, 1949. 443 p.

The readers of MENTAL HYGIENE will, I think, be mainly interested in the second part of this symposium, especially in the essays by Erich Fromm, Max Horkheimer, and Talcott Parsons, which deal with social-psychiatric aspects of family relations. As to Part I, this is a series of essays dealing with the variations in Islamic, Chinese, Indian, Russian, Latin-American, Negro, and North American family patterns. The emphasis here is mainly on family structure, not function, although the title of the book emphasizes function.

Erich Fromm reëxamines the Œdipus story and shows that it represents antagonism between father and son caused, not by the latter's incestuous strivings, but by his resentment of paternal authoritarian power. This rivalry, thinks Fromm, need not occur in our culture, where paternal authority is weak and where respect for the integrity of the child is strong. Max Horkheimer, on the contrary, argues that the modern family predisposes men to authoritarianism.

Talcott Parsons traces what he considers to be certain consequences of the structure of the modern American family. Our conjugal system fosters extreme dependence of the children on the mother, but mother love is precarious because it is conditional on the child's performance in our highly competitive social order. The girl may safely use her mother as a model, since she will follow in her mother's footsteps, but the boy, as he matures, revolts against his mother in the name of masculinity, for he comes to sense that while women are deemed good, they are also deemed to be inferior to men. The girl, however, is not spared her problem of ambivalence and instability, thinks Parsons. Hers is the dilemma of whether she shall emphasize the functions of the mother and play the domestic rôle, or assume the functions of the wife, emphasizing sexual attractiveness and glamour.

These discussions by Fromm, Horkheimer, and Parsons are highly provocative, but they concern hypotheses that are not readily tested by empirical methods.

M. F. NIMKOFF.

Bucknell University, Lewisburg, Pennsylvania.

EMOTIONAL DISORDERS OF CHILDREN: A CASE BOOK OF CHILD PSYCHIATRY. By Gerald H. J. Pearson, M.D. New York: W. W. Norton and Company, 1949. 368 p.

This book is mainly devoted to a presentation of the psychoanalytic point of view in the field of child psychiatry. There are chapters on the study and diagnosis of psychiatric problems in children; on the major syndromes, including the anxiety states, anxiety and conver-

sion hysteria, the interrelationships of organic and psychic illness, obsessional neurosis, intellectual retardation, sexual perversions, psychoses, and character neuroses; and on treatment. Over sixty case examples are presented, some briefly and some at considerable length.

The author's main interest seems to be a formal, systematic, and generally technical discussion of the dynamic psychopathology in emotionally disturbed children. The hope is expressed that the book will be especially useful to the general practitioner and the pediatrician, and will acquaint them "with the basic facts of the structure of the personality, and with the situations and influences that produce pathological disturbances."

One might well wonder about the usefulness of an approach that seems to take so little account of the usual resistances to the acceptance of unconscious content by persons who have not had the benefit of psychoanalytic training. The author makes no attempt to adapt psychoanalytic concepts to the differences in professional orientation of the non-psychoanalytic groups he would like to reach.

It is of interest that very little concession is made to the value of non-psychoanalytic approaches to children's problems. The need for treatment of the parent is mentioned briefly, and never in the sense of coöperative treatment as practiced in child-guidance clinics; in fact, the more frequent reference is to the harmful influence of the parent on the child. The use of child-guidance clinics as a treatment resource is not even mentioned, nor does the author point out that child analysis is of almost no practical importance in the country as a whole, since there are so few child analysts.

The diagnostic categories used by the author might also be questioned, since he does not differentiate childhood syndromes from those of the adult. Although the present standard nomenclature in child psychiatry is far from satisfactory, it does at least concede the differential points that the child is engaged in a developmental process, and that conflicts in children are likely to show a lesser degree of internalization than in the adult.

However, if one discounts the author's inflexible and one-sided views on treatment, and his diagnostic prejudices, there is a great deal in the book of value to persons professionally interested in the emotional problems of children, particularly the personnel of psychiatric clinics, hospitals, and institutions for children. The case material is valuable in revealing the unconscious sources of symptomatic behavior in children, and in illustrating the dynamic concepts on which an understanding of such behavior must be based.

JULES V. COLEMAN.

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THE CREATIVE NURSERY CENTER. By Winifred Y. Allen and Doris Campbell. New York: Family Service Association of America, 1948. 168 p.

Among the books dealing with nursery-school practice that have been published in this country, this is the first to present the child's development along psychodynamic lines. It is a book that breaks new ground in several areas. It emphatically draws a line between the custodial care given in the old-fashioned day nursery and the newer centers whose program compares well with that of any good nursery school.

In the part that deals with the nursery-school program proper, this reviewer misses a presentation of some of to-day's undecided and urgent questions; for instance: When and why is full-day or half-day attendance preferable? What about spaced attendance? Should groups have a wide or a narrow age range? Should the same teacher stay with her group for one or two years or longer? Should all children be requested to lie down in the middle of the morning and after lunch, or can the need for relaxation and temporary isolation from the group be met in other ways?

In the part in which administration and nursery-school practice overlap are some excellent points. For instance, staff meetings are discussed in practical detail. There is also a paragraph on the conflicts that are aroused when a child is assigned to a group in which his own mother is a teacher. There is an extensive review (over ten pages) of what it means for parent and child to leave the day nursery. One wonders why there is nothing on the related problem of the child who leaves his group, his teacher, and his friends in the middle of the school year because the entering or the leaving of other children suggests a regrouping. Yet in most day-care centers this is a constantly recurring problem.

The book's last part, dealing with administration, financing, and the functions of the board member, is done most carefully. One feels an earnest desire to convince the reader, to present material that is well organized and to the point. Is the book written primarily for board members? It would be a pity if its many valuable suggestions should miss the professional audience.

A few years ago O. H. Mowrer, professor of education at Harvard, wrote about the mutual attitude of teacher and psychotherapist: "It is not remarkable, therefore, that there should be a lack of understanding and sympathy between those persons whose professional activities center around the preservation and perpetuation of cultural patterns and those persons whose main business is to protect and rehabilitate disorganized individuals."

This description of professional activities has in the past fitted the teachers of older children, but it does not fit the nursery-school teacher. The focus of her work is not so far removed from the business of the therapist. It is the guidance of individuals who need special protection and who in a sense are disorganized on account of their immaturity. The days when the teacher of older children centered his work around what to teach, with little concern for the needs of those whom he was teaching, are rapidly coming to a close.

Is it too much to hope that the philosophy of the nursery school will gradually reach our public-school system, pervading and transforming it? A book like the one reviewed here provides several stepping stones in this direction. It was printed through the Henry H. Bonnel Fund.

LILI E. PELLER.

The City College of New York.

PSYCHOLOGIST UNRETIRED. THE LIFE PATTERN OF LILLIEN J. MARTIN. By Miriam Allen deFord. Stanford University, California: Stanford University Press, 1948. 127 p.

Any one who lives past ninety deserves to be written up, particularly so when the nonagenarian continues to make an outstanding contribution to human welfare during the years of retirement, as did Professor Lillien J. Martin.

In this book Miriam deFord has given us a lively account of a remarkable woman whose influence was felt far beyond academic walls. There are brief glimpses of Miss Martin's childhood years; her career as a student at Vassar, where she specialized in science; her early teaching in Midwestern and West Coast high schools; her four years with the psychologist, Wundt, at Göttingen; and her subsequent years until her retirement in 1917 as professor of psychology at Stanford University.

But the best years were yet to be. As the book's title suggests, Miss Martin's retirement was in name only. The most important part of her career, her work for humanity, was still to come, the most fruitful period of her life. At eighty she remarked that she was entering upon the best years of her life. She refused to decline, preferring to look ahead continually and to try out new ideas.

On retirement from Stanford in 1917, she put to use, in the interest of mankind, the accumulated experience of her life up to that time and her matured insights. At that time she determined to become a consulting psychologist, one of the first women to enter this field—in fact, one of the pioneers who helped to create this new professional field. Her early consulting work was done with children and their parents,

later with shell-shocked men whom she returned to active service through her counsel. Finally she directed her energies toward rehabilitating and salvaging the aged, contributing much to our knowledge of a new science, gerontology. In 1929 she opened the first Old Age Counseling Center in the country.

Miss Martin's unusual gift for friendship was strikingly shown in the human relations she practiced throughout her long life. She could always find time for her greatest love—people. Her approach to human adjustment problems was invariably practical and social. She was sympathetic, yet sensible. In dealing with people's problems, she discovered that kindness was more effective than severity. The keynote of her success in psychological counseling was client participation, foreshadowing modern methods in psychotherapy. She believed that any real change in behavior or attitude must come from within the client himself. In counseling perturbed persons, she recognized the interdependence of body and mind, anticipating psychosomatic medicine.

The author gives enough information about Miss Martin's place in academic psychology to interest the scientific reader, but not too much to discourage the layman who is chiefly interested in reading an interesting life story. The book is delightful reading because it sounds the optimistic note that characterized Miss Martin's full years.

GERTRUDE HILDRETH.

Brooklyn College, New York City

READINGS IN THE CLINICAL METHOD IN PSYCHOLOGY. Edited by Robert I. Watson. New York: Harper and Brothers, 1949. 740 p.

Dr. Watson has selected from the journals forty-nine articles relating to the clinical method in psychology. These articles are classified under four general headings, which make up the four sections of the book: *Clinical Method, The Functions of the Clinical Psychologist, Diagnostic Methods,* and *Methods of Treatment.* Four articles, one for each section, have been especially prepared for the volume by Dr. Watson himself. The functions served by the editor-author are the integration of the material of the various authors and the addition of other material considered pertinent. His selections are competent, with the result that comparatively little is left for him to contribute as addenda. The value of the book is none the less enhanced by the editor's comprehensive summaries, and his evaluations of trends suggested by the progressive assembling of material.

The book opens with Loutitt's 1939 publication on the nature of clinical psychology, which is an account of the trials and tribulations of the clinical psychologist, evaluated with reference to the historical

background. The tremendous developments that have taken place in the professional practice of psychology are seen by the editor as extensions of the positive trends emphasized in Loutitt's review. The professional relationships of the psychologist to the psychiatrist and to the social worker are examined critically, and dissensions are analyzed in the light of our knowledge of the nature of interpersonal relationships and therapeutic procedures. The constructive suggestion is made that we use what we know in our professional problems of maladjustment; and specifically, certain definite plans are formulated for the improvement of interpersonal professional relationships.

The clinical method in science is discussed historically by Thorne, and the barriers of isolation that have impeded the mutual development of medicine and psychology are shown to be artificial. One never fails to be impressed with his extensive knowledge of the two disciplines.

Donald G. Paterson provides a survey of the development of modern guidance, pointing out obstacles that have been hampering its progress, and closing with an optimistic prediction of better things to come from the newer type of guidance. The mass errors of educational traditionalism are beginning to be broken down and, hopefully, the stage is set for progressive individualized educational techniques in more of our high schools, colleges, and universities.

Laurence F. Shaffer considers the relationship of clinical psychology and psychiatry, analyzes some of the reasons for discord between psychiatrists and psychologists, and offers constructive criticisms. Training in clinical psychology is classified by David Shakow with reference to four main trends: the dynamic, the diagnostic, the diagnostic-therapeutic, and the experimental. Dr. Shakow's classification provides a useful means for categorizing the psychological services provided by different mental-hygiene clinics.

In the second section, the functions of the clinical psychologist in the psychiatric hospital, in a Veterans Administration mental-hygiene clinic, in child guidance, in a school system, in student personnel services, in an institution for the feebleminded, and in the prison situation, are discussed in turn by experts in these fields. The significance of past and current trends for future developments is emphasized.

In the section on diagnostic methods, we look for and find those two prolegomena for projective methodologies—Rosenzweig's *Fantasy and Its Study by Test Procedures* and Frank's *Projective Methods for the Study of Personality*. These two articles supply for the student of clinical psychology a sound and stimulating philosophical background and emphasize the full import of the specific diagnostic procedures that make up the remainder of this section.

Ideally, the evaluation of the several methods of therapy should,

we believe, present clearly the different therapeutic systems and then let the data speak for themselves. Dr. Watson has done just this. The compelling conclusion is that therapies—all therapies—apparently produce beneficial results in many cases. Some therapists want to believe that their particular systems are most effective. Future researches will determine specifically what is good in the several methods of approach. In the light of our present knowledge, the general common denominator seems to be the salutary personal relationships of patient with therapist.

Excellent extensive bibliographies are given for each section. Students of clinical and abnormal psychology will also be delighted to find an index. Only those who have attempted to index a multi-authored volume of this general type can realize the task involved in such indexing.

These readings provide a source book of much significant material in abnormal and clinical psychology. The selection of the articles is such that current trends and important developments are brought into clear focus.

EDWARD S. KIP.

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THE BASIC NEUROSIS. By Edmund Bergler, M.D. New York: Grune and Stratton, 1949. 353 p.

Edmund Bergler's new book is intended to present his fundamental thesis, developed from his twenty years of analytic work. One can summarize the vast amount of work that he has done by his conclusion that every neurosis is a consequence of oral regression, and that the various types of neurotic symptomatology are "rescue stations" along the lines of libidinal development.

The author has arrived at the conclusion, based upon his rich clinical material, that the neurosis starts with the infant's fury at being refused oral nutriment. The child's helplessness requires him to repress this aggression. Therefore, he feels moral reproach and guilt. Out of such experiences arise a state of "psychic masochism" which is repeated throughout life as an unconscious wish for humiliation and defeat. The infant defends himself against this situation by aggression and indignation. Other defenses are added as development progresses on the urethral, anal, and phallic levels. Hence, neurosis represents in general and in particular a defense against this basic psychic masochism arising out of oral rejection in the earliest period of development.

Bergler's interests in psychoanalysis have been varied, his publi-

cations have been many, and he is thoroughly familiar with neurosis, both therapy and theory. The present book is full of clinical material and the ideas are carefully worked through. This volume is far more suitable for the practicing analyst than for the lay public, chiefly because of its theoretical implications and its many practical hints.

The tone of the volume is a little unusual; the author's vigor and élan have led to a polemical spirit and a strong assumption of infallibility. The writing is always interesting, sometimes amusing, though occasionally the author seems to strain in his effort to get a striking phrase. For example, in discussing promiscuity, he states (p. 174): "Grotesquely, wolf and wolferette are the unhappy prey of each other"; or again (p. 36): "The neurotic idyll is the infantile paradise, paid for with unhappiness." Occasionally some of his mots are apt, as (p. 143): "The sheer number of orally regressed people is amazing. I have the impression that the bulk of neurotics has a rendezvous with orality."

It is obvious that Bergler has thought through the whole gamut of neurotic reactions. It is also obvious that he enjoys his work intensely. Thoroughly familiar as he is with the terrain of the unconscious, he can have a field day with other analysts who do not quite agree with his views.

In summary, this volume is one that every analyst should read. It is vivid, and contains important implications for psychoanalytic therapy and psychiatric thinking.

WALTER BROMBERG.

Reno, Nevada.

EMOTIONAL SECURITY. By M. R. Sapirstein, M.D. New York: Crown Publishers, 1948. 291 p.

One of the greatest barriers to psychiatric progress has been the division of the field into different schools of psychiatric thought. Many of these schools have evolved theoretical doctrines and methodological approaches that seemingly are worlds apart. However, a penetration of the semantic barriers within which the schools are entrenched often reveals that differences in theory and especially in practice are not so profound as one would imagine.

In recent years a number of attempts have been made in the current literature to evaluate critically the formulations of the various psychiatric schools, to distill from them basic principles, and to blend these into a common frame of reference. The present work by Dr. Sapirstein constitutes the most highly organized attempt in this direction.

The book is divided into three parts. Part I deals with the basic principles of psychoanalysis and outlines a historical review of psychoanalytic theories of the neuroses, the causes of anxiety, the basic defenses against anxiety, and their impact on individual and social adaptation.

Part II concerns itself with sexual adjustment, and deals with the vicissitudes to which the sexual impulse is subjected in our culture, and the neurotic consequences resulting therefrom.

Part III discusses a variety of topics, including hostility, the traumatic neurosis of war, psychosomatic disorders, and creativity. There is also a brief chapter on the therapeutic value of psychoanalysis.

Dr. Sapirstein has structured the content of the book to high-light the more recent ideas and revisions in psychoanalytic theory. One senses an attempt to deal honestly with basic issues about which much current controversy rages.

Emotional Security is a well-written and provocative book, and should prove useful to students of psychiatry, social work, and psychology, as well as of the other social sciences.

LEWIS R. WOLBERG.

New York City.

THE MEANING OF ANXIETY. By Rollo May. New York: The Ronald Press, 1950. 376 p.

This book is an outstanding contribution to the literature dealing with anxiety, and reading it should be regarded as a "must" by every one interested in or dealing professionally with problems of behavior.

In large measure it is a presentation of the best thinking in regard to anxiety of leaders in philosophy, psychology, biology, and psychiatry from the 17th century to the present day. But the material is not only a compilation; it is analysed, clarified, and synthesized in such a way as to make significant the trends in understanding the rôle of anxiety in behavior. No mention is made of Krishnamurti or his ideas, but he is not generally enough known so that one could call this an oversight.

The author has the happy faculty of locating the crucial point in each person's contribution, of giving it the value and weight that it is entitled to, of discarding the fumblings of these giants without belittlement or superciliousness, and of making the reader see the various disciplines in their relationship to one another.

The first part of the book presents the development of modern interpretations of anxiety, with a chapter devoted to each of the following topics: Philosophical Predecessors to Modern Theories of

Anxiety (Spinoza, Pascal, Kierkegaard); Anxiety Interpreted Biologically (Goldstein, Grinker, Spiegel, Cannon, Dunbar, Alexander, Lewis, Symonds, Saul, Wolff and Wolff, and so on); Anxiety Interpreted Psychologically (Mowrer, Freud, Rank, Adler, Jung, Horney, Sullivan); Anxiety Interpreted Culturally (the author draws extensively from Fromm); and a Summary and Synthesis of the Theories of Anxiety.

Part II presents thirteen case illustrations oriented toward demonstrating the validity of the theory of anxiety which the author has arrived at in Part I, plus a chapter on the general conclusions to be drawn from the case illustrations.

The book is scholarly, with ample reference material. It is not dogmatic, but at the same time it leads one inexorably to fairly definite conclusions in regard to anxiety and behavior, many of which conclusions are somewhat at variance with currently accepted concepts (Freudian).

Whereas each person's concepts add their something to an understanding of behavior as motivated by the fear of anxiety, the leaders at present on the horizon, who are largely determining immediate future progress in insight, would seem to be Goldstein, Mowrer, Fromm, and Sullivan. This represents a pronounced shift toward a social and moral orientation in psychiatry, and a further integration of philosophy and psychiatry.

Possibly one of the reasons why the book delighted me so much was that I had the feeling that I was on common ground with the author—that he, on the basis of careful study of the best recorded thinking concerning anxiety, had arrived at conclusions comparable to my own, which were based, not on study of the writings of people, but on contact with the people I had seen as a practicing clinician.

CAMILLA M. ANDERSON

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A PSYCHIATRIST LOOKS AT TUBERCULOSIS. By Erick Wittkower, M. C. London, England: The National Association for the Prevention of Tuberculosis, 1949. 151 p.

A comprehensive study of the psychologic aspects of tuberculosis has been needed for a long time, and has only been awaiting a capable investigator with the will and the opportunity to undertake it. Dr. Wittkower qualifies for the task and fulfills these requirements. Many previous authors have considered, more or less briefly, small segments of this problem, but in the present study 785 patients

were interviewed "for at least two hours—many for a much longer period." The author did all the work himself, and realizes that it suffers for lack of control cases, but he is justified in inquiring, "Where will one get 785 so-called normal patients to submit to two- or three-hour psychiatric examinations?"

The interview in each instance comprised (1) the taking of a clinical history; (2) an assessment of the patient's reaction to the illness, its treatment, and its implication; and (3) an assessment of the patient's previous personality and life situation at the time of onset of the disease. The policy adopted was "to draw out the patients rather than to question them." Supplementary information was secured from families, nurses, members of the staff at sanatoriums, and the like. Those who might object to the omission of psychologic testing the author refers to Mr. Bhandari's thesis on the pre-morbid personality of tuberculous patients, a work that is being done under the author's supervision and that is now nearing completion.

The book is written predominantly for those in care of tuberculous patients, and, therefore, is devoid of technical psychiatric language. The problem is considered in three chapters entitled, *The Behavior of Tuberculous Patients, Factors Determining the Behavior of Tuberculous Patients,* and *The Relevance of Emotional Factors in the Etiology and Course of Pulmonary Tuberculosis.*

The first chapter considers such important things as the patient's reaction to the symptoms, the diagnosis, and the illness. The author finds the commonest reaction to the intimations of the diagnosis to be one of shock, and, therefore, whatever is said, the patient's personality should be taken into consideration. Dr. Wittkower confirms the opinion of most investigators who have written on the subject that "most tuberculous patients are in a depressive and anxious mood." These thoughts and feelings are due to many things in addition to the physical symptoms, and he feels that during the initial stages, patients should be allowed to indulge these feelings without too much interference, for they have, he says, reason to feel depressed. He rightly insists that knowledge and understanding of these emotional reactions seem to be essential for anybody who has to deal with tuberculous patients, professionally or otherwise.

In the remaining chapters, he considers such things as the extent of the lesion and the type of emotional reaction, the personality of the patient, the environment and its effect on the patient, the sexual feelings of the individual under study, and other subjects.

The work is a valuable one for all persons interested in tuberculosis. The caliber of the psychologic observations is of course ex-

cellent and the work is thorough, as would be expected of this author. The format and layout of the book are poor, however, and as a result the reader receives an impression of unevenness that detracts from the pleasure of reading the volume, though not from its usefulness.

F. J. Braceland.

The Mayo Clinic, Rochester, Minnesota.

Introduction to Psychiatric Nursing. By Marion E. Kalkman. New York: McGraw-Hill Book Company, 1950. 336 p.

Introduction to Psychiatric Nursing is a recent addition to the rapidly increasing literature in this field. In his preface, the author states that the book is called an "introduction" for two reasons: first, because its purpose is to present psychiatry to nurses who are unfamiliar with the subject; second, because it is designed to indicate how nurses employed with psychiatric patients can become contributing members of psychiatric teams.

The material presented here has been used by Miss Kalkman for a number of years in teaching affiliating nurses, so it is not new. Acknowledgments are made to numerous sources from which it was obtained. The contents are arranged in five parts, with twenty-two chapters and an index. Comprehensive reading references follow most of the chapters.

The first part presents preliminary considerations, and instructs the student how to observe patients. Kretschmer's body types are described and line drawings illustrate the various types. Normal sensorium and intellectual qualifications with deviations are described in the text and illustrated by graphs.

Part two consists of three chapters on understanding the patient. The usual developmental patterns are described, beginning with the prenatal period, including physical and psychological inheritance, prenatal and birth experience, and continuing on through the various age levels, with accompanying emotional development and variations.

Part three, made up of three chapters, describes what can be done for the patient. It points up the significance of the individual's history and the information obtained from the psychiatrist's examination in assisting the nurse to participate in the treatment prescribed. Shock treatment, lobotomy, prolonged narcosis, and the use of carbon dioxide are described. Technics are not included and the results of treatments are not estimated.

Suggestion, hypnoses, interviews—social, directive, and psychiatric—are mentioned in one or more paragraphs under psychotherapy.

Psychoanalysis and hypnotism are described in greater detail. Group therapy and psychodrama are mentioned briefly.

Part four devotes seven chapters to a description of how the psychiatric nurse works. Her function as an observer and a recorder of patients' behavior is considered in detail. Methods of dealing with patients with various behavior problems are presented.

The fifth part consists of five chapters of suggestions for the nursing care of various types of patient.

The text will probably be most useful in the situation in which it was developed. Much of the material presented is generally accepted by nursing educators, but some of the suggestions are disputable. For example, not every nursing director or instructor would agree that a young nurse should be "prescribed as companion to a patient" at concerts or entertainment away from the hospital because such attendance involves too much responsibility for an inexperienced person. Also, a young student of twenty years or so may find difficulty in adopting a "warm maternal attitude" toward patients of her own age or older.

The concept that dynamic psychotherapy is of recent development also may raise a question. Nurses who have been interested in and have actively promoted the development of nursing in general and psychiatric nursing in particular for more than twenty-five years may recall dynamic psychotherapy successfully operating before that time. Some of our distinguished nursing educators and administrators were the valued associates and welcomed assistants of well-known psychiachiatrsts prior to the quarter century specified as the beginning of dynamic psychiatry.

If the suggestion that nurses undertake personal analyses is taken seriously by a large number of those engaged in psychiatric nursing, qualified analysts will probably have more applicants than they can reasonably be expected to care for. Personal analysis is required as part of the training of a psychiatrist who plans to undertake psychoanalysis as a therapy, but the obligation is not the same for nurses because they do not treat or interpret behavior.

A goodly number of nurses have been successful in psychiatric nursing for many years, and have been reasonably happy in their personal adjustments, without analysis. On the other hand, some report benefits from analysis, so it is probably an individual need, not a general requirement.

MARY E. CORCORAN

National Institute of Mental Health, Bethesda, Maryland

NOTES AND COMMENTS

Third Annual Meeting of the World Federation for Mental Health

The Third Annual Meeting of the World Federation for Mental Health was held in Paris, France, from August 31 to September 7, 1950. It was attended by 225 delegates and observers from member societies, from 27 countries. The work of the conference was performed in small discussion groups, where the topics selected for discussion at the annual meeting were considered and recommendations formulated. The findings of each working party will shortly be made available by the World Federation for Mental Health. The four topics were: Leadership and Authority in Local Communities; Industrial Mental Health; Mental Health and Education; and Mental Health and the Problems of Transplanted Persons. Newly elected officers of the federation for 1950–51 are: William Line, Ph.D., Toronto, president; Alfonso Millan, M.D., Mexico City, vice president; and Dr. M. K. el Kholy, Egypt, who continues as treasurer.

Two important decisions were reached. The first was to open membership in the World Federation for Mental Health to individuals who may wish to subscribe a minimum of $3 a year to the purposes of the federation. "Associates," as they are to be called, will have the right to attend public sessions of future meetings and will receive the annual report, but will have no voting privileges. This change will enable the constituent member societies of the federation to canvas their individual members as well as interested individuals and give them an opportunity to become associates.

The second decision of importance is the fact that the Fourth International Congress on Mental Health will be held in Mexico City in December, 1951. The topics for discussion at the congress will be the same as those listed above, with the addition of one or two others to be announced at a future date. An official announcement of the congress will shortly be issued in London, New York, and Mexico City, and will go to all interested individuals.

The United States delegation, of which Mr. Herschel Alt was chairman, hopes to make it possible for many institutes to be held throughout the United States prior to the Mexican congress, thus taking advantage of a unique situation that may never arise again. Many eminent European mental-health experts, as well as those from other countries, will be coming to Mexico, and hence will be available for lectures, institutes, and seminars, with honoraria attached, in the

United States, for the period from November 29 to December 6, 1951. Inquiries should be addressed to Mrs. Grace E. O'Neill, National Association for Mental Health, 1790 Broadway, New York 19, N. Y.

Midcentury White House Conference on Children and Youth

The Midcentury White House Conference on Children and Youth will be held at the National Guard Armory, Washington, D. C., December 3–7. This is the fifth of such conferences, which are held approximately every ten years. The theme of the present conference is: "A Fair Chance for Every Child to Develop a Healthy Personality."

The conference will be attended by over 5,000 leaders in health, welfare, education, and religious and civic activities for children and young people in this country, as well as by several hundred representatives from abroad. For further information, write to Miss Elma Phillipson, Consultant in Public Coöperation, Midcentury White House Conference on Children and Youth, Room 5526 FSA Building, Fourth and Independence Avenue, S.W., Washington 25, D. C.

News of Mental-Hygiene Societies

Compiled by

Marjorie H. Frank

State and Local Organization Section, National Association for Mental Health

Arizona

Arizona has moved ahead in plans for the organization of a state mental-hygiene society. At a meeting of more than 60 persons on August 3 in Phoenix, a temporary organizing and planning committee was formed, with Mrs. John M. Williams, of Phoenix, as chairman. Dr. Edith Lord, Chief of the Division of Mental Health of the State Health Department, will act as secretary of the organizing committee. A meeting is to be held this fall at which the final plans for the society and its program will be presented.

California

On a recent field trip to the West Coast, Miss McBee, of the National Association for Mental Health, met with the Board of the Mental Health Society of Northern California to discuss plans and programs. The 18 affiliated county chapters are carrying on educational programs in their communities. The San Francisco Chapter

is working for an increase in the number of psychiatric beds in the city hospital in San Francisco.

At the present time, the Northern California Society has no executive. Dr. Nathan Adler is its president. The new address of the organization is 101 Post Street, San Francisco.

The Board of the Southern California Society for Mental Hygiene met with Miss McBee, of the National Association for Mental Health, on August 9. The board is interested in program planning and the relationship of the mental-hygiene society to other community agencies. Miss McBee gave a review of the organization and activities of other mental-hygiene societies throughout the country.

Connecticut

The Connecticut Society for Mental Hygiene reports that it is most fortunate in having Mr. John Dollard as its new president, as his distinguished career has given him a broad knowledge of the problems and practices of mental hygiene. Mr. Dollard, professor of psychology at Yale University, has been associated with the Institute of Human Relations since 1932. He served as an expert consultant to the Secretary of War in the Research Branch of the Division of Information and Education, dealing with problems of morale. His work prior to this included numerous social studies and research projects which are reflected in his publications, some of which are: *Caste and Class in a Southern Town, Criteria for the Life History, Victory Over Fear,* and *Fear in Battle.* Mr. Dollard brings to his new office not only the capabilities that he has developed in his years of research and teaching, but also a real conviction of the importance of the task of the society.

Mrs. Anthony V. Lynch, retiring president, will continue to give her active support to the society as one of its three vice presidents, the other two being John H. Jackson and Royden K. Greely.

Florida

The Mental Hygiene Society of Northeastern Florida has recently completed an institute which met every Monday night for eight weeks. The interest shown during the hot summer months was phenomenal. The attendance at the sessions varied from 80 to 120. In all almost 400 people attended at least one session. It was interesting to note the various occupations represented in those attending: educators—15 per cent; health workers—12 per cent; doctors—2 per cent; social workers—18 per cent; church workers—3 per cent; civic workers—5 per cent; persons in business—12 per

cent; students—1 per cent; housewives—21 per cent; farmers—1 per cent; unidentified as to occupations—10 per cent.

Each session consisted of a main speaker—usually a local psychiatrist—with two or three other community members participating in a panel discussion. Audience participation was unusually good. The sessions were devoted to the following topics: (1) Prenatal and Infant Care; (2) Children from One to Six; (3) Children from Seven to Twelve; (4) Adolescents; (5) Adults; (6) Middle Age and Old Age; (7) Adverse Effects of Poor Mental Hygiene; and (8) Mental Hygiene and the Community.

On Wednesday, August 23, the society sponsored a lecture by Dr. William M. Cruickshank, Director of Special Education for the Exceptional Child, Syracuse University. Dr. Cruickshank was brought to Jacksonville by the board of public instruction to conduct a two-weeks workshop for teachers of exceptional children. He kindly consented to lecture for the mental-hygiene society, and in connection with the publicity for this lecture, was featured in a fifteen-minute radio interview.

The education committee of the society, headed by Mrs. W. C. Sumner, former child-welfare worker, and Dr. Gary A. Turner, psychiatric consultant to the Veterans Administration, are largely to be credited with these projects, which called the society to the attention of the whole community and set the pace for a very active fall schedule.

The Mental Health Society of Southeastern Florida reports that the board of commissioners of state institutions approved the plan recommended to inaugurate a long-term advanced-planning program for the Florida State Hospital, and requested that an application be made for a federal grant of 50 per cent of the cost of planning, constructing, and equipping the proposed new male receiving unit.

At the convention of the County Judge Association held recently in Kissimmee, conditions at the Florida State Hospital and the Farm Colony were discussed. Ways and means whereby the association could assist in the effort to get more facilities for these institutions was a major topic.

Hawaii

Mrs. Margaret D. Hackfield, Executive Secretary of the Mental Hygiene Society of the Territory of Hawaii, has resigned from her position because of ill health after four years of service. No appointment has yet been made of a successor.

The society is beginning a new series of meetings, entitled "Understanding Ourselves." The meetings are led by Dr. Joseph H. Simon,

psychiatrist, and are devoted to discussions of personal problems. Audience participation is a feature of the discussion.

The society is also starting the broadcast of the third series of *The Inquiring Parent.*

In coöperation with the territorial department of public instruction, the society is working to bring Miss Mildred Sikkema, Excutive Secretary of the National Association of School Social Workers, to the islands this fall, to interpret and promote a more extensive program of mental hygiene in the schools. Funds for this are being provided by a local foundation and will be administered by the mental-hygiene society.

Illinois

The Illinois Society for Mental Hygiene, along with other member agencies of the Health Education Committee of the Welfare Council of Metropolitan Chicago and teachers and parents, engaged in a four-day workshop at Northbrook, Illinois, September 5–8. Understanding the emotional needs of the child, with emphasis upon the ways in which teachers and parents can help to meet these needs, was the subject of the study. The society feels that this kind of coöperative project serves a dual purpose in providing an educational experience in mental health, not only for the lay groups, but for the multi-discipline agency representatives who participate in planning and conducting such a workshop.

On June 28, the state society met with representatives of local societies, including those of Champaign, Peoria, Rock Island, Springfield, and Winnebago counties, to discuss and exchange ideas on operation, program, and goals. Dr. Walter Baer, of Peoria State Hospital, extended the hospitality of his institution for this one-day session. Members will be informed via the society's newsletter of significant developments growing out of the meeting.

During the months of July and August, representatives of health and welfare agencies, as well as leaders of selected civic organizations concerned with mental health, were offered the opportunity of previewing films concerned with psychiatric concepts, at the offices of the Illinois Society for Mental Hygiene. The results of evaluations growing out of this program were submitted to the Publications and Reports Branch of the National Institute of Mental Health. Of the six films presented, the Vassar film, *Meeting Emotional Needs In Childhood,* and the navy medical film, *Psychosomatic Disorders,* were considered especially pertinent to agency programs concerned with mental-health education. It was the consensus of the group that similar preview programs would be of value to them in evaluating such educational media.

Indiana

The Indiana Mental Hygiene Society, organized a little over a year ago, now has chapters in nine of Indiana's 92 counties, with several more ready to affiliate. Two of the chapters arranged exhibits for their county fairs, and the state society had an exhibit at the state fair in coöperation with the Indiana Council on Mental Health. The Marion County Chapter will sponsor its second mental-health forum in November.

A high-school principal asked the state society to arrange a one-day institute on mental-health for the teachers, parents, and administrators of three townships. It was held on August 31.

The facilities committee is working on material to present to the state legislature. The executive director has made field trips throughout Indiana.

Radio stations are making good use of the transcriptions the society has available.

Louisiana

The Louisiana Society for Mental Health calls our attention to a publication called the *Human Relations News Letter.* The society originated it with the idea of providing interpersonal stimulation for those teachers who were using the Bullis outlines entitled *Human Relations in the Classroom.* The newsletter has been very successful and there are seven hundred on the mailing list. The publication will be continued this year.

The society is collaborating with the state hospital board and the state department of health in distributing the new prenatal *Pierre the Pelican* series for the state of Louisiana.

It will again conduct its "Louisiana Attendant of the Year" contest, but this time the attendant chosen must have read some standard material written especially for his profession and must have taken a written examination upon it. Thereafter, the person rated highest by his fellows, his superiors, and the patients will be given the award. The society states that it is going to try to introduce as much learning as possible into the contest.

Maryland

The Mental Hygiene Society of Maryland reports that it has spent most of the summer months in planning the coming year's program. The budget for 1951 has been prepared by the finance committee and the personnel-practices committee has begun drawing up standards for the agency. Plans have been made for the work

of the public-education committee and the necessary subcommittees have been organized to implement the work. These subcommittees will carry the following respective responsibilities: to develop an educational program for the society's own chapters and committees; to develop such a program for interested civic and lay groups, and to be prepared to meet with such groups in an advisory capacity; to offer psychiatrists and personnel in the allied professions an opportunity for training in discussion leading and group dynamics; to consider, and to make recommendations for, the educational material in *Spotlight*; to survey and evaluate plays and radio scripts, and make recommendations; to survey and evaluate films and make recommendations; to survey and evaluate pamphlets, books, and exhibits, and make recommendations; and to plan the society's Second Annual Institute on Religion and Mental Health.

The committee, necessarily a large one, will open the season with one full meeting, and from then on will meet in subcommittees to carry out the program. Dr. Ridenour, of the National Association for Mental Health, has agreed to address the opening meeting.

The volunteer program in the state mental institutions has continued through the summer, although reduced by vacations. A committee, representing the society, the Maryland Occupational Therapy Society, and the state institutions, have met and planned the Second Annual Training Course for Occupational Therapy Volunteer Assistants, which will start the middle of October. The two councils of community agencies organized to serve the state hospitals—one council for the hospitals near Baltimore and the other for the hospital on the south shore—will meet in October to form active subcommittees and to plan a long-term program.

Massachusetts

Mrs. Irene Malamud is acting executive director of the Massachusetts Society for Mental Hygiene, following the resignation of Mr. William Savin, who had been executive director for the past three years.

In the society's June newsletter we note that Mrs. Malamud, and Mrs. Dorothy Parker, Consultant, Community Mental Health Programs, served as group leaders at a two-day mental-hygiene institute for public-health nurses held at the Metropolitan State Hospital. The theme of the institute was "Mental Health as an Integral Part of All Nursing." Dr. Paul V. Lemkau, Director, Mental Hygiene Study, Johns Hopkins University, opened the institute, addressing about 200 enrolled public-health nurses, school nurses, and visiting nurses. He set as the keynote of the meeting the importance of

"the awareness of personality" in the field of public-health nursing. The public-health field is pioneering in the recognition of the important rôle played by interpersonal relationships in all aspects of health. After Dr. Lemkau's opening speech the nurses dispersed into 15 groups of from 10 to 15 members each. On succeeding days Mrs. Malamud and Mrs. Parker led a group discussion among public-health supervisors.

The institute program included a showing of the U. S. Public Health Service film, *Preface to Life,* with Dr. Lemkau leading a panel discussion on its content. The institute closed with a summary of the findings of the various group discussions. Arrangements for the conference were made by Miss Frances Thompson, Chief Supervisor of Psychiatric Nursing for the Massachusetts Department of Mental Health.

The Turning Point, the weekly mental-health radio series sponsored by the society, has been broadcast through the coöperation of Station WEEI's department of public affairs, headed by Fred Garrigus. It featured *ad lib* interviews with actual persons who have emotional problems. This format, originated by radio commentator Susan A. McAvoy, of the society staff, differs from other mental-health series which use written dramatizations and actors.

Mrs. McAvoy has interviewed seventeen psychiatrists, psychologists, and psychiatric social workers as guest experts during the series. She is at present tape-recording other experts, as well as patients, for *The Turning Point.*

The society participated in the Fourth Annual Meeting of the Massachusetts Public Health Conference and the New England Health Institute by showing mental-health films and exhibiting literature.

In spite of reduced attendance during the vacation months the volunteer program at the Metropolitan and Foxboro State hospitals has progressed. Beginning in the fall, forty volunteers are enrolled for each hospital. This is approximately twice the number of last year.

The society's student program now includes three students, one from the Boston College of Social Work and two from the Boston University School of Social Work. Training is given in psychiatric case-work, as well as in the society's approach to communities that request help with their mental-health problems.

The Bristol County Mental Health Clinics, Inc., have now raised sufficient funds to warrant the employment of their first psychiatric team. This will serve the areas of Fall River, Taunton, and New Bedford on a part-time basis. As funds are available, three other

teams will be required to complete the personnel necessary to serve the county.

Four other areas in the state are in the process of organizing similar clinic services. Three of these are using the society as consultant and its experience in Bristol County is being used by the fourth.

The society, in coöperation with a group of educators, has planned a one-day mental-health institute for the teachers of Massachusetts. This will be held at Harvard, Friday, October 13, 1950. Dr. Roma Gans, professor of education at Columbia, will be the principal speaker.

The institute will accommodate 150 to 200 teachers, who will take part in discussion groups. Each group will be led by a team, consisting of a psychiatrist, an observer, and a recorder. The discussions will cover the various areas of the emotional and social development of the child.

Michigan

The Michigan Society for Mental Hygiene informs us that the first part of one of the most important jobs it has ever undertaken was successfully completed June 21, when the Michigan Legislature, without a dissenting vote, passed enabling legislation for a bond issue to permit the immediate construction of mental hospitals.

The legislative action will place on the ballot in the November 7 general election a proposed amendment to the Michigan Constitution which will authorize the issuance of up to 65 million dollars in bonds for mental and tuberculosis hospitals, with 60 million dollars for mental hospitals and training schools for the mentally handicapped.

A state-wide citizens committee has been incorporated which will be responsible for the educational work of explaining to the voters the importance of approving the bond issue in order to help solve the serious mental-health problem that confronts the state.

The board of directors of the society voted to sponsor five one-day regional conferences in lieu of the three-day annual conference held in Detroit. It is felt that more lay persons will be able to participate in the regional meetings. The conferences will be held in Grand Rapids, Bay City, Lansing, Detroit, and the northern peninsula. The general theme of the meetings will be "Developing Skills of Living in an Upset World."

The Genesee County Chapter drew a large audience for their panel discussion on the topic, "The Mental Health Picture in Genesee County," with Mr. William R. Brown, chapter president, as chairman. The participants were Hon. William E. Doran, Judge of the Juvenile Division of the Probate Court; Hon. John W. Baker, municipal-court

judge and President of the Council of Social Agencies; R. Gordon Brain, M.D.; Jerome Fink, M.D., Pontiac psychiatrist; and Herbert J. Booth, of the state department of mental health.

The Ingham County Chapter has organized a speakers' bureau of nine persons.

A panel of three persons discussed "The Mental Health of Our Community," at the annual meeting of the Ingham County Council of Social Welfare. The participants were Mr. Herbert Bodwin, of the department of mental-health; Dr. D. Stanley Coors, Chairman of the Ingham County Chapter; and Mrs. Ruppert Spaulding, of the Family Service Agency of Lansing.

At the annual mental-hygiene institute of the Kalamazoo Chapter, held May 17 at the Kalamazoo State Hospital, 124 persons were registered and heard discussions on child and adolescent behavior by Mrs. Ara Charbonneau Cary, of Grand Rapids; Mr. Ralph Daniels, of the state department of mental-health; and Dr. Leonard Rosenzweig, of Grand Rapids. The mental-health film, *Preface to Life,* was shown by Mr. Daniels as a basis for his talk. Dr. Morter, Superintendent of the Kalamazoo State Hospital, and Miss Martha Yackel, Consultant on Community Mental Health Programs, the Michigan Society for Mental Hygiene, spoke informally on the legislative situation.

The Kent County Chapter became affiliated officially with the state society at its annual meeting on May 24. Miss Yackel, of the Michigan Society for Mental Hygiene, met with the executive committee of the chapter to discuss its future activities. The chapter is making extensive plans to broaden the scope of its services in Kent County.

The Midland County Chapter is continuing its efforts in working with the neighboring counties to establish an adult mental-health clinic. Board members of the chapter have been speaking before groups on the need for community understanding of and participation in preparing for such service. The executive committee is studying a plan to increase its membership to include broader representation of community interests.

Mrs. Henry S. Booth, President of the Oakland County Chapter, reports that approximately 1,500 persons attended the six meetings presented by the chapter during the past year for members and the general public. Several board members are active in the Citizens' Committee on Alcoholism which has recently been organized in Pontiac. The film, *Human Growth,* has been used quite extensively in the past several months by other groups in Oakland County.

The Tri-County Chapter reports that attendance at its lectures has

grown from about forty to well over 500, the attendance at its last lecture. The program committee has met several times and has arranged a series of lectures for the coming year.

Montana

The Montana Society for Mental Health is a new, but active, state society. Dr. E. A. Atkinson, of the Department of Psychology, Montana State University, Missoula, is its president, and Mrs. Dorothy Cassutt, of the state department of public welfare, Helena, is chairman of the activities committee. On July 8, a meeting was held in the senate chambers of the State Capitol Building at which 50 members were present. Miss Marian McBee, of The National Association for Mental Health, spoke on program planning in mental-health organizations. The society is planning the development of county chapters throughout the state.

North Carolina

From the July newsletter of the North Carolina Mental Hygiene Society, we learn that, as a culmination of Mental Health Week activities, a large group of persons in Salisbury attended a meeting and voted to organize the Rowan County Mental Hygiene Society. They plan to make a community survey to determine the mental-health resources available and then to develop activities to meet the unmet needs.

After an extensive education program promoted by the Health and Welfare Division of the Rocky Mount Woman's Club, the Rocky Mount Mental Hygiene Society was organized. The society plans to concentrate on study programs for groups.

The Third Annual Rural Health Conference sponsored by the North Carolina Health Council and the Rural Health Committee of the Medical Society of the State of North Carolina met in Raleigh, June 14–15. One of the group meetings considered the problem of the confinement of mentally ill persons in jails. Resource consultants were representatives of the state mental institutions, the sheriffs' association, local hospitals, departments of public welfare, and mental-hygiene societies. The state society reports that it feels local mental-hygiene societies could profitably study this problem in their own communities. There is a need for a correct diagnosis of mental patients held in jails, immediate application to the correct state institution for those needing commitment, development of local hospital care for those needing temporary treatment, and

planning for aged senile persons who should not be sent to state hospitals. The Medical Care Commission will approve the construction of special rooms for temporary care of mentally ill patients in hospitals now being built with funds from the Hill-Burton Act, if the local community requests it. Boarding homes for the aged are being developed and licensed by the state board of public welfare.

October 11, 1950, was the date set for a mental-health institute sponsored jointly by the North Carolina Mental Hygiene Society and the North Carolina Mental Health Council.

The society's education committee has worked with the officials of the Women's Prison, Raleigh, in developing a rehabilitation program for the women. Meetings have been held both in Raleigh and in Chapel Hill and projects have been initiated. Committee members have also served on other committees. They have supported a request for the services of Austin H. MacCormick, who has just completed a survey of prisons in North Carolina.

Ohio

The Ohio Mental Hygiene Association reports that it has ten affiliated county societies and a number of additional preliminary organizations through which it has been conducting educational programs. Institutes and workshops have been conducted by the local groups with the assistance of the state association.

The Ohio Institute on Mental Hygiene of Family Relations was jointly sponsored by the Ohio Mental Hygiene Association and the Ohio Council on Family Relations. Several family-life institutes were jointly sponsored with other local groups. Mental-health institutes are being planned in coöperation with local Councils of Jewish Women.

Both the state association and the local county mental-hygiene societies have participated in the program of the Ohio Commission on Children and Youth. The executive secretary, Mrs. Marion S. Wells, has been named one of the official state delegates to attend the Midcentury White House Conference on Children and Youth in Washington, December 3–7.

Mrs. Wells is serving as secretary of the Mental Hygiene Committee of the Ohio Program Commission, whose purpose is to examine the entire effort of the state in this field and to recommend a program of mental hygiene that will be adequate to the growing proportions of the problem and in keeping with the improved methods of treatment and administration. The areas of study include: (1) organizational status and methods of administration of the agency administering mental-hygiene in the state; (2) organization and development

of local mental-hygiene clinics; (3) laws relating to mental hygiene; (4) charges to relatives for the care of inmates in state mental institutions; and (5) personnel and training programs.

The following activities are reported by county societies:

Mahoning County Mental Hygiene Society sponsored an institute on child guidance, on October 3, in connection with its annual membership drive. A child-guidance clinic sponsored by the Youngstown Junior League has been opened. Dr. Merrill Evans, chairman of the society's program committee, reports that for 1950–1951 there will be special programs on the problems of older people, mental-hygiene programs in courts and schools, mental hygiene and the church, and a mental-hygiene workshop for teachers.

The Montgomery County Mental Hygiene Association reports that the Third Annual Dayton State Hospital Summer Internship Course ended successfully with an attendance figure of 160 persons. A wide variety of professions were represented in this group. They included social workers, nurses, case-workers, teachers, ministers, a lawyer, an occupational therapist, a psychologist, and a physician. The purpose of this course, which included sixteen special lectures along with other features, was to offer opportunities for psychiatric orientation to those who have human-relations responsibilities. The course was conducted over a period of eight weeks, and college credit was available for those who wanted it.

Plans are being made for the Fourth Annual Mental Hygiene Institute, which will be held on November 2. The theme this year is "The Emotional Needs of Children" because of the general interest in the White House Conference on Children and Youth. Special workshop sessions will be held in the morning on the following topics: "The Gifted Child," "The Retarded Child," "The Infant," "The Family," and "The Teen-Ager." General sessions will be held in the afternoon and evening. All meetings are open to the public, with no charge for admission. Last year's attendance was approximately 1,100.

A Council on Retarded Children of Montgomery County has been organized for the benefit of retarded children, their parents, schools, and communities. Though this council is only a few months old, many such groups over the country have been functioning for years. On September 28, 29, 30, and October 1, representatives of all such groups met in Minneapolis for the purpose of organizing a national federation of these councils. Their aim is to coördinate services for the retarded child, give mutual aid, and raise funds for public education and for the improvement of programs for retarded chil-

dren. Dr. Alfred Kamm, Executive Secretary of the Montgomery County Mental Hygiene Association, was a member of the steering committee of this conference.

North Franklin County Mental Hygiene Society devoted its September meeting to "The Legislative Front." Dr. Calvin Baker, Commissioner of Mental Hygiene, and Mrs. Marion Wells presented the program for discussion. Mrs. Harvey Walker, chairman of the program committee, reports that various special projects are being considered for volunteer participation for the coming year. The membership committee reports one hundred paid-up members.

The Toledo Mental Hygiene Council, under its constitution, pledged itself to sponsor four general meetings during the year. These have been (1) in February, 1950, the annual meeting of the council, at which Dr. Calvin Baker, Commissioner of Mental Hygiene in Ohio, spoke on "Ohio's Progress in Mental Hygiene"; (2) in March, 1950, a reception honoring Dr. N. P. Dallis, the council's former director, and Dr. J. M. Kenyon, its new director; (3) in May, 1950, a joint meeting with the Family Life Education Program, at which Dr. Fischer, of the Temple University School of Medicine, spoke on "Child Guidance in the First Half of the Twentieth Century"; (4) in October, a joint meeting of the council and the health section of the local Council of Social Agencies, dealing with some aspects of the problems of the aged. In addition, the council is active in reviewing local facilities for mental hygiene as part of the nation-wide White House Conference.

Wayne County Mental Hygiene Society reports that during the summer months the executive committee has met regularly to discuss plans for fall activities. The education committee has been preparing a series of weekly articles on mental hygiene to appear in the local newspaper during the winter, and has been working on a bookshelf of mental-health pamphlets for the lobby of the new community hospital. The speakers and films bureau of the society has been preparing material to meet requests for programs during the year. It has arranged to have the film, *City of the Sick*, shown in the Health Tent at the Wayne County Fair in September. The society also plans to hold several open meetings during the winter and to conduct some mental-hygiene meetings for special groups such as teachers and ministers.

Knox County Mental Hygiene Society has completed its affiliation with the state association, reporting fifty charter members. Miss Audry Wright, chairman, is naming the committees and plans to develop a worth-while community program.

The monthly publication of the Ohio State Department of Welfare,

Public Welfare in Ohio To-day, is mailed to all members of the Ohio Mental Hygiene Association and its affiliated county societies. In the July issue, an article was devoted to Governor Frank J. Lausche's report on the mental-health program which he delivered last June as chairman of the 1950 session of the Governors Conference at White Sulphur Springs, West Virginia. The findings and recommendations were grouped into four major items: 1. The demands of state hospitals for the care and treatment of the mentally ill have increased many times more rapidly than the increase in population. 2. Increased facilities for the care and treatment of the mentally ill have not kept pace with the constantly increasing growth in case load of mentally ill patients. 3. What are the basic reasons why mentally ill patients committed for care and treatment to the state have increased out of proportion to the increase in population? 4. What should be done to meet the situation as it now confronts us? Copies of this issue of the publication may be secured by writing to The Ohio Mental Hygiene Association, 1014 Huntington Bank Building, Columbus 15, Ohio.

Oregon

The Mental Health Association of Oregon informs us that the major summer-time public program sponsored by the association was the presentation of the film, *The Quiet One,* in coöperation with the Portland summer session of the Oregon State System of Higher Education. During a one-day showing, the film was seen by 2,200 persons.

The association's primary goal for the summer has been the setting up of a new committee structure, which can be characterized by assignments specific enough to enable the membership of the committees to show realistic progress.

A major goal for the next few months is to develop graphic material that will be effective in portraying the association's total program quickly. The need for this became apparent, the association states, at the presentation of the program before the Portland and Oregon Community Chests. However, despite a rather weak presentation, the association was allocated an increase for next year.

Plans for the immediate future include a complete study of the three state institutions before the legislature meets; participation by the association's staff or by volunteer representatives in several teacher institutes; and a possible conference of county welfare workers at the Eastern Oregon State Hospital. A review of the use of jails for the detention of the mentally ill is being started.

It is hoped that the new journal, *Pastoral Psychology,* will help the association to reach an increased number of ministers. A mental-

health display at the annual session of the Oregon State Medical Society should help to reach more general practitioners.

A possible two-year project is contemplated in the preparation of a manual for the use of persons associated with commitment procedures throughout the state. The first step has been to ask qualified persons to prepare a statement as to their respective rôles in commitment—a judge, a district attorney, a public-health officer, a welfare worker, a private physician, and so on.

The association reports also that two more counties in Oregon will have part-time clinical service during this next year. One of these will operate in conjunction both with the county health department and with a teacher-training college. The Multnomah County Health Department, which employed a full-time mental-hygiene consultant last year, has now employed a health educator. One of his specific instructions is to develop a comprehensive mental-health-education program.

Pennsylvania

In the July issue of *Pennsylvania Mental Health News*, we are informed that Pennsylvania has now accepted National Mental Health Act funds and the state department of welfare has established a new division of community services under the direction of the commissioner of mental health, Hilding A. Bengs. The first full-time appointment in the new division, which is under civil service, is Mrs. Malcolm H. Oettinger, who assumed the position of chief psychiatric worker.

Coincident with the adoption of the new Pennsylvania Citizens Association constitution, its division on mental health undertook expansion of the division committee to bring about greater state-wide participation in the operating, policy-making unit of the division. Five new sections of the division committee have begun functioning together with those centering in Philadelphia and Pittsburgh. The Northwest Section has had three meetings, one in Meadville and two in Erie. The West Central Section had two meetings in Altoona. The East Central Section has had four meetings in Harrisburg and the Mid-East Section has met twice in Bethlehem. The Northeast Section has met twice in Scranton and once in Wilkes-Barre.

The types of meeting held and the topics considered have been quite varied because of the differing problems of organization and the newness of the expanded program. Emphasis in the Northeast has been on the community programs under the National Mental Health Act. Several sections have discussed the problem of the care of mental defectives. Much time has been spent in most of the sec-

tions in orientation to the Pennsylvania Citizens Association program and to state-wide mental-health problems. A schedule of four stated meetings during 1950–51 for each section was prepared in August. It is expected that a more uniform agenda will be developed for consideration at each of these meetings. It was felt that with the expanding community-service program of the bureau of mental health and with a new legislative session approaching, much needs to be done by the Pennsylvania Citizens Association's Mental Health Division and its sections.

South Dakota

The South Dakota Mental Health Association reports in its July newsletter that with the enthusiastic coöperation of the Black Hills Chapter, the Veterans Administration Hospital did an outstanding job in public relations on Hospital Day. This society feels that if a well-planned Hospital Day program could be provided annually at Yankton and Redfield state hospitals, much more coöperation on the part of the public with the programs of these institutions would be forthcoming, and the association hopes to work for this next year.

The Veterans Administration Hospital at Fort Meade has an active volunteer program and the association would also like to promote a volunteer project at Yankton and at Redfield.

An amendment to the constitution of the South Dakota Mental Health Association, providing for the affiliation of local chapters with the state association, was endorsed and later ratified by the board of directors. The Black Hills Chapter is now legally part of the state association.

Dr. E. S. Watson, president of the association, represented the state department of health at the Mental Health Institute for Public Health Physicians at Salt Lake City, June 12–22. Emphasized was the inclusion of mental-health programs in health departments. Each afternoon, doctors of the institute worked with patients in various public clinics in Salt Lake City, discovering how many emotional problems were being missed entirely in routine health examinations.

The South Dakota Mental Health Association helped to organize a pastoral-counseling institute which was held at the University of South Dakota in July. The central theme of the institute was a program of education for better mental health. Outstanding speakers were obtained: Dr. Carroll Wise, Head of the Department of Pastoral Counseling, Garrett Biblical Institute; Dr. Roy C. Knowles, of the Menninger Foundation; Dr. Forrest Weller and Dr. Henry Cobb, of the University of South Dakota; Rev. Charles Bullock, a graduate of the Yale School of Alcoholic Studies; Victor Hammer; Dr. F. W. Haas;

Professor Nelle Hartwig; and Professor Gerald Fort. Contact was made six times with 750 ministers in the state relative to the institute. Dr. I. D. Weeks, President of the University of South Dakota, gave his enthusiastic support, and the university was the financial sponsor of the institute. R. D. Falk, director of extension, did a tremendous job of organizing and publicizing the institute. Dr. A. A. Schade, Executive Secretary of the South Dakota Council of Churches, enlisted the unanimous endorsement of the council and publicized the institute among council members. The state department of health sponsored the institute also in furnishing mental-health films and literature.

The association held its annual meeting on October 11, 12, and 13 in Huron, in conjunction with the South Dakota Conference of Social Workers. The 12th was Mental Health Day for both organizations.

The association also reports that, though it has no membership committee, its membership has jumped from 147 last October to 443 to date. It hoped to reach 500 by the time of the annual meeting.

The governor has invited representatives of the South Dakota Mental Health Association to sit in on the hearings of budgets for state institutions, and the president of the association and others will attend.

The association offered a mental-health platform plank to the Democratic and the Republican Party, with the resulting adoption of brief statements by both parties.

Virginia

The Mental Hygiene Society of Virginia informs us that it has been busy during the summer through its educational department in planning for programs with schools in several of the localities during the fall and winter. Planning also has been made with various groups, such as women's clubs and Parent-Teacher Associations, for programs during the fall and winter months.

During the summer two mental-health workshops were held—one at Mary Washington College and another at the Virginia State College.

Reports on the activities of some of the local chapters—Lower Peninsula, Charlottesville-Albemarle, Northern Virginia, Richmond, and Caroline County—indicate their particular interest in the education of the public on mental health.

Washington

In the July newsletter of the Washington Society for Mental Hygiene, we note that a reorganization plan resulted from the evaluation

survey of the society. It was felt that reorganization was necessary to reach the main objectives of the society since these could not be realized if confined within a local area, as most of the problems are on a state-wide basis. This is true particularly in the legislative field, involving the mentally ill, custodial schools for juveniles, state aid to the handicapped, state support for guidance clinics under the public-health department, and support for the public-school system. Also included in the committee's analysis were recommendations concerning aims and purposes, reference services, coöperation with other groups, division of activities (state, regional, and local), and finance. The committee's report will be made available to each unit for discussion and action.

For the first time in twenty-two years, the society held its annual meeting in eastern Washington. Official host to the delegates was the Northeast Mental Hygiene Society (Wenatchee Unit). Dr. L. C. Miller, President of the Wenatchee Unit, presided at the opening session of the two-day conference, held in Wenatchee, May 12–13. Dr. Douglass W. Orr, the principal speaker, discussed "Mental Hygiene in Everyday Life." Other participants at the meeting included Robert E. Conner, Dan Prosser, Howard E. Ordway, Dr. Stephen Fleck, and Dr. Sidney Bijou. George F. Ault, executive director of the society, gave a progress report, "New Horizons for Mental Hygiene." Dr. Charles R. Strother, newly-elected president of the state society, presided over the discussions. Reports from standing committees and local-unit presidents were also included.

The legislative committee of the society reports the following findings of the Youth Protection Act: The basic difference of opinion on this bill is between those who believe (1) that there must be a definite line of responsibility to the governor (the elected officer responsible to the people) from the directors or superintendents of institutions and that, therefore, these appointive officials must be removable by him at his pleasure; (2) that continuity of program is possible only when leadership is not subject to political change.

The Youth Protection Act has been studied by many groups over long months. One of two new sections or additions provides for the establishment of forest or farm camps, parental or intermediate schools, and diagnostic and special facilities, as may be necessary for the treatment and rehabilitation of delinquent children. The mental-hygiene society has long endorsed such progressive social reform. It realizes, of course, that progress in this program will be dependent upon appropriations by legislatures, but in that very fact lies the answer to those who fear that this act will cost the state too much money. Upon the recommendation of its legislative committee, the

board of directors of the society has voted to support the Youth Protection Act.

Commander Harold E. Baxter, M.D., was recently elected President of the Kitsap County Mental Hygiene Society.

The Thurston County Mental Hygiene Society (Olympia) reports a continuance of community discussions led by the unit on such subjects as juvenile delinquency, alcoholism, and family relationships. Facts have been gathered on a study of community services by members of the Olympia Unit, and a 15-page report has been submitted to the executive committee of the state society. The Thurston County Committee will evaluate the survey, as the second step in the study.

A major contribution of the Seattle-King County Unit to the mental-hygiene movement is the newly organized Mental Hygiene Service Guild, composed of women who are vitally interested in civic and social reform. The guild is holding out a helping hand to people who are confined in state institutions. Their first project was the furnishing of a commons room for the Boys' Training School at Chehalis. Adviser to the group is Mrs. Marjorie Creim, former president of the state society. The Washington Society has asked units that desire information regarding the development of guilds to get in touch with the state office.

Acting as a sounding board for needs that have been expressed by community groups, the Education Committee of the Seattle-King County Unit either initiates ideas for educational programs, or discusses suggestions made by the board.

Consideration of the value and methods of distribution of mental-health literature is also a concern of this committee. Together with the program chairman, the education committee is presently planning with the Counseling Department of the Seattle Public Schools for a series of discussion meetings on some aspects of mental-health. The committee is interested in helping in the development of more of this type of small-group discussions or workshops.

According to Mrs. Bernard J. Gallagher, President of the Eastern Washington Mental Hygiene Society, the Spokane Unit has carried out an interesting series of public lectures under the able leadership of Mrs. Elmer Ballo, program chairman. The unit has held six public meetings, drawing in a cross section of the community and presenting a stimulating discussion of timely topics. The subjects included "Problems of Adolescents"; "Causes of Mental Illness"; "Maturity—Our Goal"; "Alcoholism"; and the "Over-dependent Child." Speakers include representatives from medicine, social work, and education.

The work of the Yakima County Mental Hygiene Society has been

partially responsible for the development of a section in the new hospital in Yakima which is to be used exclusively for the treatment of mentally ill patients. Norman Johnson, President of the Yakima Unit, reports that sessions held on mental-hygiene, which included discussions of the family court, were very successful. *The Devil in Yakima County,* a series of six newspaper articles by Ray Ruppert, which appeared in the *Yakima Republic,* revealed the extent of mental illness in Yakima County and challenged community leaders to create public awareness of an accepted national-health problem. Reprints of the series in pamphlet form will be made available to each of the units and to individual members upon their request.

A special project of the Southeastern Washington Mental Hygiene Society was assisting the state society with its survey of state custodial and correctional institutions. A committee of three, headed by Miss Sarah Corcoran, President of the Walla Walla Unit, prepared a report on the Washington state penitentiary, with special emphasis on improvements needed for the rehabilitative facilities of the institution. According to Miss Corcoran, the unit hopes next fall to sponsor one or more courses in mental hygiene under the adult-education program at Walla Walla High School.

Wisconsin

The Milwaukee County Society for Mental Health reports that the president of the society is gradually inviting each committee chairman to meet with the executive committee, so that a clear picture will be obtained about the work of the committee and the funds necessary to carry out the committee projects.

The public-relations committee was active in arranging publicity for the Colonel Bullis Conference on June 30. This committee also publicized the *Hi, Neighbor* radio series held during the summer and the Mental Health Education Workshop, as well as editing, planographing, and mailing 650 copies of the June newsletter.

A special committee was set up by the Junior League of Milwaukee County, a member of the Milwaukee County Society, to assist with the mailing of the newsletter.

The program and activities committee scheduled the first board orientation seminar on "Mental Health Education in the Schools of Milwaukee County." The second seminar subject was "Mental Health at the Collegiate Level."

The committee on institutional-service units sponsored a unit at Milwaukee County Asylum from June 16 to August 11. Of the six students enlisted, only three remained to the end. Positions had been approved by the county board of public welfare for 12 students

for a three-month period. The committee found it impossible to fill these positions because the students received a weekly stipend of only $18.00, not including room and board. Mrs. Mary Moss Cuthbertson, Executive Director of Institutional Service Units, American Friends Service Committee, visited the I.S.U. in August and met with the committee and representatives of the Milwaukee County institutions. The administration is willing to continue the program in 1951 on the 1950 stipend basis.

The American Red Cross Volunteer Committee continued to bring 15 Gray Ladies Motor and Arts and Skills Services to Milwaukee County Asylum. The recruitment of additional volunteers is continuous through radio appeals, talks, and so on. The Milwaukee County Chapter of the American Red Cross furnished a fruit punch, which was served by their canteen services, to about 1,200 patients at the July 2 picnic at the asylum. Gray Ladies assisted with the picnic.

The institutions entertainment committee continued their square dances at the Milwaukee County Hospital for Mental Diseases until the end of June and hopes to resume the program this fall.

The committee for mental-health education in schools held a mental-health-education workshop from July 10–14. The Milwaukee County Society feels that this has probably been the biggest and most stimulating mental-health event ever scheduled in Milwaukee County. Participation far exceeded the expected enrollment of 50–100, with nearly 300 registrants. A complete report will be available in the fall for 50¢. A few brief quotes from the preliminary report on the Mental Health Education Workshop, by Helen L. Dunlap, Ed.D., general chairman, follow:

> "The fact that a workshop of this scope was accomplished without funds other than a nominal amount is another unique feature of this pioneer piece of work."

> "It was the general opinion that if fifty people attended the workshop, it would be a success. It was not until the middle of June that the possibility of a large enrollment was indicated. And if attendance is one measure of success, then the workshop was a successful venture."

> "Two kinds of evaluation can be made of this first Mental Health Education Workshop to be held in the Milwaukee area. . . . Enrollment and attendance were exceptionally good. There were 289 paid registration fees of one dollar; eight of these carried two people, so 297 people actually enrolled for the workshop. In addition to this number, there must have been at least one hundred or more additional college students who came in for one or more sessions and from whom no fee was received. Another evidence that the workshop was a success was the sustained interest;

the attendance held up all week, and on Friday morning, at the final meeting, which dealt with reports and evaluation, it was unusual—there were over one hundred and twenty-five people.

"A second measure of the value of the workshop was the interest shown by the parents. As the first workshop for parents and teachers, it is encouraging to note that 95 parents were enrolled for the workshop. Of these 95 parents, 40 were teachers. In the breakdown of attendance figures, 17 administrators and supervisors were in attendance, 10 special-education teachers, 4 social workers, 3 clergymen, and 2 librarians. As yet the exact number of people attending the three different age levels has not been secured, but a brief count indicates the largest enrollment in the early elementary (ages 4–8), the next largest in the secondary (ages 13–17), and the lowest in the upper elementary (ages 9–12). The numbers on the evaluation sheets—and these were not received from *all* who attended the workshop—were (ages 4–8) 156; (ages 9–12) 59; (ages 13–17) 72.

"A third type of objective evidence that pointed to the value of the workshop was the practically unanimous request for another such workshop next year—117 said they wanted a workshop, 1 said no. Of the people replying on the evaluation sheets, 67 said they wanted the length to be 1 week; 43 said 2 weeks or more; and 4 indicated such varying lengths of time as 3, 4, or 10 days.

"The second kind of evaluation that can be made of the worth of the workshop is largely subjective in nature. In trying to assay how people felt about the workshop, an evaluation form was provided them on which they could state what they thought they got out of the workshop and what kinds of experience seemed most helpful to them. Films, speakers, and materials (books, bulletins, book lists, etc.) were the three most frequently named as being most helpful. All of the people who attended the two days of demonstrations in the teaching of human relations in the classroom situation (fourth-grade and seventh-grade pupils were used in these demonstrations) felt, too, that these demonstrations gave them something tangible to follow up and try out in their own teaching situations.

"One of the most encouraging aspects of the workshop project was the way in which so many people gave so unselfishly of their particular talents and time. Perhaps this is one of the evidences of the worth of the project, for from the first it caused people *to give* in a liberal and wholehearted manner such as they had to offer. Colonel Bullis and the professional people from the Scott, Foresman Company came without fee. Nine local psychiatrists participated in the program; more than a dozen local psychologists served; while Dr. Anderson, of the U. S. Public Health Service, worked with us for the week, Mr. Abramovitz, from the Wisconsin Public Health Department, gave us three days, and Miss Catherine Brophy, school psychologist from Sheboygan, gave us the entire week. In addition to this, several school principals and supervisors and parents gave their time for the week. Leadership in the Wisconsin Congress of Parents and Teachers, the Milwaukee State Teachers College, the Milwaukee County Society for Mental Health, and the Milwaukee Public Library was used effectively over a period of weeks in making the workshop an endeavour of real worth."

Workshop highlights were: parents, teachers, principals, educators, psychiatrists, psychologists, clergymen, and others, all working together; no outside financial aid, some funds through co-sponsors, much volunteer work; a continuous spirit of good will and a demonstration of mental-health in action, chiefly inspired by the general chairman; an evening symposium, open to the general public, on the subject, "The Community Working Together for Mental Health," attended by 4–500 people; attendance and expert assistance on the part of out-of-town and out-of-state experts (the state board of health, the U. S. Public Health Service, the Scott, Foresman Publishing Company). Workshop evaluation blanks show an almost unanimous request for a 1951 workshop of two-weeks duration.

The society reports that its plans for the next quarter are for further issues of the newsletter; plans for a printed bulletin; orientation seminars; and the first annual meeting of the society, which is scheduled for November 9, 1950.

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